Family Violence in the Army Research Conference

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Family Violence and Trauma Project
Department of Psychiatry
Uniformed Services University of the Health Sciences
Bethesda, MD 20814

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A conference was held at the Uniformed Services University of the Health Sciences (USUHS) to formulate a research agenda in the field of family violence for the Army. This conference included some of the leading experts in family violence research in the United States, Army representatives with a wide range of clinical, administrative, and research experience in family violence, and senior members of the USUHS faculty of the School of Medicine. The topics of the technical presentations were physical and sexual child abuse, and spouse abuse treatment and research. Several presentations were given to the invited group of participants by concerned leaders of the Army and the Department of Defense and by top researchers and clinical practice experts in the United States on the state of the research on child and spouse abuse. Other participants were also experts in Army family violence, in medical research and practice, in policy and administration, and in other specialized topics in the field. Recommendations are summarized in a separate volume entitled Army Family Violence Research Conference Recommendations.

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Executive Summary

A one and a half day conference was held at the Uniformed Services University of the Health Sciences (USUHS), the military medical school, in Bethesda, Maryland. The purpose of the conference was to formulate a research agenda in the field of family violence for the Army. This conference included some of the leading experts in family violence research in the United States, Army representatives with a wide range of clinical, administrative, and research experience in family violence, and senior members of the USUHS faculty of the School of Medicine. Several presentations were given to the invited group of participants by concerned leaders of the Army and the Department of Defense and by top researchers and clinical practice experts in the United States on the state of the research on child and spouse abuse. Other participants were also experts in Army family violence, in medical research and practice, in policy and administration, and in other specialized topics in the field.

The topics of the technical presentations were physical and sexual child abuse, and spouse abuse treatment and research. The presenters all strongly supported the Army's direction in research planning. A wide variety of suggestions and recommendations were provided by the presenters and guests. All agreed that the Army is a unique environment in which a successful research program can be conducted. This research will greatly contribute to the U.S. Army and to national priorities in understanding and treating family violence. In addition, many of these contributions to the Army environment would be applicable to the needs of the nation in these same topics.

The establishment of centers of excellence was strongly recommended. Such centers would serve a variety of research, clinical, training, policy, and command functions. A second was the need for evaluate the effectiveness of treatment of child and spouse abuse victims and offenders. The third major recommendation was for the standardization of assessments and definitions.

The recommendations are derived from the presentations and discussions of this group. They are comprehensive, feasible, and offer the Army the opportunity to increase its ability to evaluate its own efforts, plan and test new ones, train its own personnel to continue needed research efforts and disseminate pertinent, usable research information to the field on a timely basis.

The formulation of this research agenda is the first step in increasing the Army's knowledge of the means to improve the lives of Army soldiers and their family members through the reduction of family violence. Actually making this agenda into an operational plan will require the hard work and dedication of many. The proposed research plan can be the basis for a new era in the Army FAP program, one in which assessments, interventions, and prevention programs are based on the best possible understanding of the Army's commitment to its members.

Opening Comments and Introductions

Robert J. Ursano, M.D.

Moderator: James E. McCarroll, Ph.D.

DR. McCARROLL: I will introduce Dr. Ursano who will make a few remarks and then ask people to identify themselves. Doctor Emanuel will be the moderator of the first panel this morning. Following the three presentations, we will have a discussion with the audience. Doctor Ursano, would you like to make some remarks?

DR. URSANO: Just welcome. I wanted to reiterate Mr. McLaurin's comments last night that as we think about the research agenda, remember that there are really two directions where the federal government, let alone the military, excels in areas of research. It's either very creative high risk research and no one out there is going to try it because no one has the belief that it will work, or translational research. That means taking what we may know, applying it in a research way to be able to further develop its implications. I think those concepts should guide at least some of our discussion. I think our discussion should also keep in mind that the bottom line of research in the Department of Defense is always to answer the commander's question. The commander's question may be, Should I keep this person or not? The comments last night that one hit doesn't necessarily mean a second hit, but a second hit does mean a third hit can be a very helpful research answer to that question for a commander when he decides, What's my risk? that this person is going to have problems next time around.

I hope that we will work both to try and recall and articulate the commander's questions as well as brainstorm more broadly about the questions that we should try and address. I think we have a number of people around the table who can help keep us on track and make sure that we end up at a spot that will allow us to move the Army forward. I thought it would be helpful for all of us to go around and introduce yourselves so that everyone has a had a chance to put a name with a face. There's a list of attendees in your packet. Feel free to take it out and jot down, that's the one across from me, that's the one to the left, that's the one that went to the same school I did.

To begin with, I'm Bob Ursano, as you all have heard earlier. I'm a Professor and Chairman of Psychiatry here at the University. It seems like I have been here forever. I spent a career in an Air Force blue suit and it is correct to call it the Army/Air Force. I'm one of the few people who has had an ID card since birth. My father was a career green suiter, so I've always stayed very closely tied to that particular service. We have a substantial group here interested in the effects of trauma and disaster. However, my primary area is not spouse and child abuse, but it is issues of PTSD and, broadly, the questions and the effects of trauma on individuals in groups. I look forward to participating with you all. Perhaps we can move around the table to the left.

DR. O'LEARY: I'm Dan O'Leary. I'm a Professor of Psychology at the State University of New York at Stony Brook.

Maj LAWRENCE: I'm Linda Lawrence, Assistant Professor here in the Department of Military & Emergency Medicine. I'm an emergency physician with research interests, experience in death and violence.

DR. MILNER: My name is Joel Milner. I'm also a Professor in Psychology at Northern Illinois University, out in the cornfields near Chicago. I presently have a 21-year-old son and a 17-year-old daughter and those who have teenagers know why I mentioned that.

DR. HAMPTON: I'm Bob Hampton. I'm from the University of Maryland here at College Park. I'm the Professor of Sociology and Family Studies.

COL MAYS: I'm Bob Mays. I'm the Deputy Chief of Staff over at the North Atlantic Regional Medical Command. I was the Social Work Consultant to the Army Surgeon General for about five years. I served as course director for our Army family advocacy staff training course which is now a DOD course. I've been involved with various aspects of domestic violence/child abuse since 1972, since entering active duty.

COL LOCKETT: I'm David Lockett. I'm the chief of the Behavioral Health Division at the Medical Command in San Antonio. I'm the current Social Work Consultant to the Surgeon General of the Army.

DR. BREWER: I'm Brooke Brewer. I'm the Family Advocacy Program Manager at Seneca Army Depot.

CDR LAPA: I'm Joyce Lapa. I'm one of the Chief Deputy Medical Examiners at the Office of the Armed Forces Medical Examiner which is part of the AFIP, the Armed Forces Institute of Pathology.

MS. SENTELL: My name is Jeanmarie Sentell. I'm a special agent with Naval Criminal Investigative Service. I'm currently assigned to the Armed Forces Medical Examiners Office.

MS. JOHNSON: Delores Johnson, the Headquarters, Department of the Army Family Advocacy Program Manager at the Community and Family Support Center.

LTC NORWOOD: I'm Ann Norwood. I'm the Associate Chair in the Department of Psychiatry.

CDR EMANUEL: I'm Ray Emanuel. I'm an Assistant Professor of Psychiatry here at USUHS.

DR. McCARROLL: Ed McCarroll. I'm the Director of the Family Violence and Trauma Project, which is located here in the Department of Psychiatry.

DR. NEWBY: I'm John Newby and I work at the same place.

DR. JENSEN: I'm Peter Jensen. I was 11 years in the Army. I was saying last night that when you've spent a lot of time in the Army, the green in the dye of the shirt begins to sink into your skin. I transferred to the Public Health Service just before Desert Storm.

I have done a fair amount of research on military children, the Exceptional Family Member Program, and have had a lot of wonderful experiences. It's a real pleasure to be back. In my current job, I'm the Associate Director for Children's Mental Health Research at NIMH.

DR. WRIGHT: I'm Kathy Wright. I'm the Deputy Director of the Division of Neuropsychiatry at Walter Reed Army Institute of Research. I've done some research with Bob Ursano and traumatic stress is one of my interests.

DR. KOMAI: I'm Hideji Komai. I'm a psychiatrist in Japan. Here, I'm an exchange visitor from National Defense Medical University of Japan.

DR. FAFARA: I'm Richard Fafara from the Community and Family Support Center. I'm in the strategic planning office.

DR. NASH: Michelle Nash, Department of the Army, Program Analyst. I work with Delores Johnson.

DR. THOMAS: Marney Thomas from Cornell University, a very small town in upstate New York where the weather is nicer than it is here today. I'm a Senior Research Associate in the Family Life Development Center which is a group of about 40 people who study family violence. I'm the Director of the Strong Families, Strong Soldiers project on which I've been working with Delores for about five years.

DR. URSANO: Welcome to all of you. I wanted to make sure that Marney understands that her weather is only better today and that I will challenge her in January.

DR. McCARROLL: Thank you. It's my pleasure to introduce Doctor Ray Emanuel who will be moderating the panel this morning. Ray is a child psychiatrist here in the Department. He did his medical training at George Washington University and his residency in psychiatry and fellowship in child psychiatry at Walter Reed Army Medical Center. Without further ado, I will ask Ray to introduce the panel members.

Child Physical Abuse

Joel S. Milner, Ph.D.

Moderator: Raymond J. Emanuel, M.D.
CDR, MC, USN

CDR EMANUEL: When I was told who was going to be here today, when we planned this, I got very excited. All the way back in January when I first seriously immersed myself in this literature, these names were very familiar. I had seen one or two of the speakers at different conferences and was very excited for the opportunity to talk with you all and to discuss your work in some more detail. Unfortunately, we don't have a week or a month to keep you here discussing things. It would probably take the time you have to talk to do justice to your CVs.

So with that in mind, Doctor Milner will be our first presenter. He's a Professor of Psychology and a Distinguished Research Professor. He's the Director of the Family Violence and Sexual Assault Research program at Northern Illinois University. He has published more than 140 articles, chapters, and books primarily in the area of family violence. He has received research support from a variety of state and federal agencies, including the National Institute of Mental Health and the National Center on Child Abuse and Neglect [NCCAN]. His recent programmatic research efforts have focused on the description and assessment of child physical and sexual abusers and on testing of social information processing models of child physical abuse. His topic for today is child physical abuse. With no further ado, Doctor Milner.

DR. MILNER: I'd like to start with a disclaimer. I was assigned the task of talking about research trends in child physical abuse and given 15 or 20 minutes to do it. It's impossible. That is, it's impossible without being very superficial. So, last night I went through the overheads that I brought and did a lot of editing, but we're still going to go through some of the research literature because I think it informs us about the nature of some of the problems. I'm going to start out and end with this overhead. It shows a father interacting with his son. I show this because very often, we ignore the father both in research and in practice. This is a positive interaction, obviously. I'm going to make a research point related to some content in this overhead and I don't think you can guess what it's going to be. Maybe I can keep you here through the 20 minutes and we'll revisit this at the end.

I realize that I have a sophisticated audience so forgive me if, at times, I'm elementary in going through the presentation. In terms of trends, I thought we might look, ever so briefly, at the fact that there has been an explosion in the family violence journals. I happen to have a handout here with all these journals listed and I have the publishers in case you're interested (see Figure 1). Again, many of you subscribe to these. I personally subscribe to all of them. I think you need to subscribe to journals to be current. You'll notice that even in the '90s, through '97, there has been quite an explosion. If we had more time, we could discuss that in terms of trends, but I'll not do that. I've always sensed that in the last decade that there has been a reduction in the number of research studies published in the area of physical child abuse. So, I decided to go into Child Abuse and Neglect and look at all the articles and code them based upon the content. Only about seven percent of the articles in '95-'98 published in Child Abuse and Neglect focused primarily on physical abuse. These are empirical studies, 32% on sexual

abuse. Now, that 7.2% doesn't represent just the studies on the offender. Most of those are studies on the kids, victim effect studies.

Following this, I did a psych lit search from '90 to '95 and tried to answer this question. How many studies, empirical studies, controlled studies with matched groups with manipulated variables, have been conducted from '90 to '95? How many investigators have programmatic research? Meaning how many individuals have published more than two articles? Well, it turns out in that six year time frame, '90 to '95, there are only three researchers who have published empirical studies on offenders, on physical child abuse offenders. One is David Wolfe, and he's gone to primary prevention. One is Sandy Azar at Clark University. She is still doing the work, and one is myself. We account for 39% of all the empirical research. The field isn't just dying, it's almost dead. People have left it. So, there have not been a lot of new insights in the last four or five years in terms of why the physical child abuser is engaging in the abuse.

I will talk briefly about models and these are very simple ones. In terms of organizing our thoughts for all the presentations that are coming, let's go back and use Belsky's modification of Bonfrenbrenner's ecological model. This says that human behavior is determined by individual factors, and excuse me for being elementary, but there are individual, familial, community, and cultural factors. Most of the research I'm going to be talking about is located in conceptual space at the individual level. There's another organizational model I'd like to discuss briefly, that's Cicchetti and Rizley's organizational model. It looks at the characteristics of the variables. We have the four domains I just listed. This basically says there are contributing factors that are acute and chronic and there are buffering factors that are acute and chronic. The models are more complex. We generally have not studied buffering factors. So, what you can do is think about the four general domains: individual, family, community, and culture. In each one of these domains, we can talk about acute and chronic contributing and buffering factors. It doesn't tell you what contributes, but that's a nice organizational matrix. Anytime anybody presents something to you, research or a model, you can locate it conceptually within that broad framework and say, "Oh, they're focusing on this and this, but they're omitting these other factors."

Unlike ten years ago, I can now tell you there are many, many models of physical child abuse, starting with the Kempe model, the psychiatric model, then Gil's sociological model. If we had time we could discuss each one of these. I don't know what model the Army uses in family advocacy or what models you train in. I don't know if the people doing the interventions could tell you what model guides them, but I would hope they could. We train clinicians that way. Very often, people in the field aren't trained that way.

There are more models, interactional models, that are more popular these days. What I want to lead to are the trends, over the last five or six years. Well, if you look at recent model development -- if you'll allow me to summarize -- they're mainly cognitive behavioral. That's because the people doing research and writing in the area are primarily

psychologists and they subscribe to the cognitive behavioral model. We could say the research has led us to these models. To some extent that's true. But, it also represents who's remaining in the field doing the research.

Let's move to some of the factors that are seen as risk factors at the individual level. As you can see, I'm at the individual level, that's the organizational model and contributing factors. Very limited. That's what we're going to talk about briefly. These are demographics: single parents, younger parents more likely to abuse physically; educational level is lower, more likely to abuse; non-biological parent is more likely to abuse; history of abuse, both receipt and observation, are associated in lower SES status.

As you know, NCCAN is developing some risk models and very often what's coming out of the risk models are what I call static variables, such as gender. Marital status is not permanently fixed, but I don't think their treatment is going to be to get the individual married. So, some of these are static variables. The first three assessments are static variables. It's your abuse, your drug use, and the post-tests aren't going to change. In fact, maybe because you know the family better and you have more information, and the score might actually go up because they get the score the second time. They didn't get it the first time.

MS. JOHNSON: Joel?

DR. MILNER: Yes?

MS. JOHNSON: How would you view military families who are frequently separated and create a single parent effect? That's one of the issues I think we're going to have to address in the military because for some of our communities, the soldiers are deployed very frequently, creating a very much single parent effect. However, they're not single parents.

DR. MILNER: I think that single parenthood is a marker variable for lack of social support. That's my opinion. All single parents don't abuse; most do not. Something else has to be represented by the characteristic and I think it's the lack of support. The support could be economic if the second person isn't there, less than the general civilian. You don't have somebody else holding a job there to help you pay the bills. In studies I won't get into, we look at some of these factors: history of abuse, single parent status, and social support. Social support is more robust. It is really more of a main effect model than an interactional model. Social support is having somebody around to provide you with instrumental support, to help you solve specific problems. Emotional support is also extremely important. I think in the military, very often, there are support services available. They may get a visit from one of your team members if you know that they're now alone and somewhat isolated and young, where in the general community, the husband runs off, you don't get a visit just because of that. I don't know, in terms of buffering effect, how much you buffer that phenomena, but, theoretically, you're out of the money.

You have an overview of the first set of articles I wanted to review: biological factors. I'm going to talk about physiological reactivity, neurological and neuropsychological factors, and physical health problems (see Figure 2). This is going to be a rush. I'm going to be superficial, because of time constraints. I do have a chapter that just came out last month. It is a comprehensive and exhaustive review of the literature. It's not selective. It's not representative. It is comprehensive and exhaustive up to a year ago. There are no other studies in the literature that are controlled with matched groups with inclusion and exclusion criteria that are not in there. Now, when I say that, I'm sure I missed something somewhere, but it was very exhaustive. There's no large domain that I missed that parallels this presentation. Let me just discuss each one of these for 30 seconds. I also think that when you make statements, you should document them.

Physiological reactivity (see Figure 3). I'll try to be brief. People who physically abuse their children are more physiologically reactive than non-abusers to a crying child. They're also more physiologically reactive to a smiling child. We talked yesterday about child temperament. Yes, I know that's a correlated variable. But, to the extent that the parent brings a physiological liability or reactivity to that role, it's independent of what the child is doing. If the child is smiling -- this is a lab setting, of course -- and they're still showing physiological reactivity, there's something that parents bring to it that I think is independent from the child. We could disassemble this research if we had more time.

There are four studies on maltreating parents (see Figure 4). We have found that this apparently precedes having a child because we created at-risk adult groups, high and low risk. The findings aren't quite as robust because of false positives, but the high risk parents who had never had a child are more reactive physiologically to a crying and a smiling child. So, you might posit that because they've had trouble with a difficult child, they learned to see the child as an aversive stimulus whether it's smiling or not. There are other models, but the research suggests that they are reactive independently from experience with the child.

COL MAYS: What are the initials in the parentheses?

DR. MILNER: The only one that had fathers was the first one, that's MF. The rest were mothers. A means they had an abuse group; N, neglect; C, comparison and they were matched. If you look in detail at the research, what you'll find is that not any of these studies shows up on all measures of the phenomenon. I think they are GSR, heart rate, blood pressure, frontalis muscle. Anyway, they'll show it on two out of three. We are doing a meta-analysis of these data now and I was shocked at how robust the findings are when they're there. GSR is the most universal.

Elliott talked about neuropsychological differences. Rosenbaum has presented some data suggesting that there may be some brain damage in child abusers. Elliott also

says that we have not attended to minor neuropsychological deficits that exist in the physical child abuser and no one has followed that up. He used case data from a clinic, had high rates of neuropsychological dysfunction. We have a study that is now in revision where we gave a whole array of neuropsychological tests trying to look at information processing ability, verbal processing, flexibility in thinking, ability to adopt a new response choice. They were carefully matched groups except there was a ten point difference on IQ. We prorated out IQ and still had half the differences. By chance, I had included a depression and anxiety measure. When we prorated it out statistically, depression and anxiety, and there was nothing left. Now, we cannot say the kind of frequency at which abusive parents are depressed. We can not say that the depression caused inferior performance on the neuropsychological measures. We know that if you are depressed, you will perform poorly. But, there's an order phenomenon here. Do they have neuropsychological deficits which can cause the depression or did the depression cause the neuropsychological problems? The tendency is to say, "Well, the depression caused the neuro-psych problems," and here's the performance on the test, but we don't have the order worked out. And it's only one study, but it is a controlled study and they are matched.

Physical health problems (see Figure 5). I'll just quickly move ahead and tell you that in four studies, when you ask abusers about their physical health and have a matched comparison group, they indicate they have more health problems - more headaches, more backaches, don't feel good, fatigue, et cetera, whether it is somatoform type disorder, somatization disorder -- I don't know. But it is interesting and it's fairly uniform.

The next group of studies that exists are studies on self esteem or ego strength (see Figure 6). I'm not going to go through these. We don't have time. These are the major categories. We're going to revisit these as I'm presenting. These are all seen as contributors to abuse or their risk factors. I don't have the variance accounted for. I just simply put down "Yes" or "Mixed" for the findings and generally, "Yes," abusers have lower self esteem. But what does that mean? Shavelson from Stanford has a hierarchical model of ego strength and they separate out interpersonal and academic. Within academic, the child could be good in English and bad at math, you know, of course. Then they have further subdivisions. So, what are we measuring here? Is it interpersonal self esteem? Feeling that one is good in relationships which may impact how you parent or receive support from others. So, they're nice findings but it doesn't really guide intervention, to my way of thinking. It sounds good. You walk out of the room and go, "Yes, I need to work on this mother's self esteem." But, what is it you're going to do in the next 30 minutes? It doesn't tell you what to do.

Perceptions of children's behavior (see Figures 7). Mixed findings -- the general idea is that abusers perceive their children as being bad: being more hyperactive, being more oppositional, et cetera, and the findings are mixed.

More perceptions of children's behavior. This is recognition of affective states (see Figure 8). Only three studies. The first one found that physical child abusers make

more errors in reading whether the child is happy or sad, frustrated or mad in comparison groups. It's very seductive. They don't monitor their child's emotional state very well. Two studies tried to replicate, couldn't find the same results. All three groups of authors concluded that they probably do have problems perceiving the child's emotional state, but only one out of three had that finding. It's interesting how their conclusion can be different from the study results. The second two were highly critical of their own studies. We are in one of my labs trying to replicate that as we speak.

Attributions (see Figure 9). Very popular in the field since Twentyman's early work. He found, as you'll recall, that abusive parents, if their child is misbehaving, make more internal and stable attributions to that behavior. Translated, it's the kid's fault. He's going to do it again. If the kid does something positive, external and unstable – "Well, the kid is only doing it because we're sitting here watching it. He won't do it tomorrow." So, it's externally caused and it's not stable. He said that -- and it's very seductive -- low risk for non-abusive parents is the opposite. If the child is doing something negative, they think, "Well, it's unstable. It's not like he would do it again," and it's external. "He's doing it because we were loud last night when he was trying to sleep and we kept him up." So, it's external and unstable.

Of course, if the child does something positive -- puts together a little truck or something at Christmas, it's internal and stable and global. Yes, the child wants to be creative, wants to put the truck together. "He's going to do the same thing tomorrow probably. In fact, he may be an engineer when he grows up." How's that for global. We do that in our personal relations. As you know, in therapy you can predict, based on the attributional style of the individual, the likelihood of them getting divorced or separated during marital therapy. If the wife or husband is saying, "He always does that," or, "She always does that," and, "It's his fault." This is internal and stable. The prognosis is much more negative than if it's situational and not generally global. So, attribution -- that's the model. Most of the attempts to replicate have not replicated that, or they found one difference like on internal/external, not some of the others. So, I'm not so sure whether the attributional style is generally different. I think there are some data to suggest that they attribute hostile intent to the kid's behavior more often. Whether it's across all areas of global internal/external and so forth, I don't know.

Evaluation of children's behavior (see Figure 10). They see, especially in every day living situations, mildly negative behavior as more wrong and bad than the rest of us. If a kid is five minutes late getting to bed, how wrong is that? They'll see it as more wrong than you or I. Wrongness is important. Can you replicate this? Why? Because if the behavior is wrong it justifies more severe disciplinary action. You get the idea that when something is severe, then it justifies a more severe disciplinary action. I think these people see these minor transgressions as more wrong. There may be a whole array of reasons: low self esteem, misunderstanding of children's behavior, their competency ability. What's also interesting, in a child development paper we published, when they saw minor transgressions as more wrong, following punishment the high risk parent predicted greater compliance following discipline for the minor transgression and less

compliance when they disciplined for something major like getting into a fight with the kid next door. Low risk folks were the opposite. What I'm saying is, if a kid goes to bed five minutes late or reads a comic book under the sheets with a light or something, they think the child is not going to do it again.

What do you think? Well, you think, the odds are, minor transgression, they're going to do it again. So, they're also setting themselves up. I don't really understand unless they just think kids are bad, why they think the kid is not going to comply with discipline after the serious transgression. The rest of us would say, "No, my son is not going to do that again, or my daughter," but they're the reverse. So, the expectation interacts with the transgression. It's not just higher or lower expectations. It's the context of the transgression. That's why I say we have to get into the trenches here. This is a very complex issue we're dealing with.

Expectations of children's development and behavior (see Figure 11). Fascinating area. People generally believe that abusers have too high expectations for child development. If you review the control studies for this matched group, actually, what you find in the matched group studies is that the comparison and the abuse group have little knowledge of developmental milestones. You match my SES in education. People just do not know. How old is a young boy when he's potty-trained, on average? Fully potty-trained, what's the average age? Average age for a girl? Well, it's three for a boy and two for a girl. They just don't know that. A lot of us don't know. That's not too bad, actually. Anyway, if you look at the literature, it is all over the place -- too high expectations, too low, mixed findings, no findings.

Sandy Azar did several studies and she has found a consistent difference in terms of expectations of children's behavior. It's the area of complex sequences of behavior. Let me give an example -- is it appropriate to tell a toddler to take the plate off the table, put it in the sink, come back, get the glass, put that next to the sink, and take the napkin and put it in the trash? Actually, she just has two steps. I gave you three. Guess what universally happens? The abusive parent expects the child to follow the whole sequence and be successful. The rest of us go, "No way." We also do shaping. If the child takes the plate to the counter, they may get a hug, right? They've consummated the first part of the task. But that's not what happens with abusers. They think the child has failed, been oppositional, et cetera, and is deserving of punishment. I think you'll find more on that in the future. That's not just developmental milestones and that may not even be critical. It has to do with the expectations of these complex sequences of behavior.

COL MAYS: Just a comment. That expectation could be driven, for instance, by economic factors. If you can't get your child into child care until they're potty-trained and you need that done by age 14 months -- you know, because we get cases revolving around that. We're saying the developmental milestone may be two years or two-and-a-half years. We believe corporal punishment and other means of enforcing that behavior could account for that expectation. I don't know if that's factored into looking at the results, but –

DR. MILNER: Right. It's not.

COL MAYS: That is a requirement. You can't get into child care unless you're potty-trained.

DR. MILNER: Those are rigid expectations (see Figure 12). They have them.

Empathy -- empathy modeled aggression (see Figure 13). Empathy promotes helping behavior. Helping behavior combats aggressive behavior and except for one mixed study which we did, we found situational differences in empathy, not dispositional. Generally, the findings show, clearly show, that the abusive parent lacks empathy. It looks like a lot of studies how they certainly report more distress. However, maybe you can correct me on this, but I have not been able to find a single published study where they manipulated stress as a variable and looked at changes in attributions, expectations, et cetera. You would think that it would be there.

Stress is the most commonly mentioned construct, the most important one (see Figure 14). We actually have four unpublished theses and dissertations (see Figure 15) where we manipulated stress and tried to look at information processing differences. We got the subtle information processing differences between groups. We never got a stress effect. We tried it different ways. We know about the different models of stress, that sometimes there's a post-stress fatigue phenomena that occurs in terms of processing. We checked it there. We have predictable and non-predictable stressors.

There's a study that's correlational that's not up here that Horton did last year which is suggested to me. He says that you have to have two kinds of stress interacting to get a reaction. We've not looked at that. That is, the persons or the parent needs to come to the situation with chronic stress in life in general. Then they need to have situational child stress combined. Those two conditions can trigger different cognitions and different behaviors. Don't know if that's true, but we have a control for that chronic personal level of stress.

Negative affectivity (see Figures 16 and 17). After we dumped the psychiatric and went to a sociological model, interactional model, we got away from looking at psychological states which is negative affectivity (see Figure 18). We're back -- these people have more anxiety. They have more depression, unhappiness or sadness. It's fairly uniform, as you can see. One "No" – chronic hostility, generally more anger, hostility and aggression and more annoyed with their children.

DR. BREILING: Joel?

DR. MILNER: Yes?

DR. BREILING: If I might go back to your stress work, Emmy Warner in her Hawaii study dealt with that somewhat, didn't she, in the sense that she was -- folks that -- recently because of low income in a variety of child interaction measures and outcomes? It struck me that a major factor, certainly with Patterson's finding as well, had to do with the individual predispositions and so forth of families that were prone to be happy and positive were pretty well buffered against those stresses in terms of impact on the kids and vice- versa? So, if you're looking at the stress model, wouldn't you also want to take into account the repertoire and the predispositions of the parent?

DR. MILNER: Yes, which is what that the Horton study suggests too. You're giving me a broader representation of what you should look at. Not just their general level of distress, but also their coping skills which would include the buffering characteristics. What I'm saying is that it has not been done in a controlled fashion to get the matched group and manipulate the presence or absence of those characteristics just hasn't been done. So, you're talking about correlation.

DR. BREILING: Right.

DR. MILNER: I don't think that most of these abusive parents have DSM IV diagnoses, but they certainly appear to have more emotional problems, more emotional liability. Maybe it goes along with the physiological reactivity. Those are all controlled studies.

Behavioral characteristics (see Figure 19). Alcohol and drug use, social isolation problematic parent-child interactions, aversive parental strategies, inadequate coping, what we're going to discuss now.

Alcohol use (see Figure 20). Only one controlled study where they actually gave different amounts of alcohol, or allowed them to consume different amounts of alcohol under different conditions. Alcohol is in vogue. Has been in this culture for five or ten years. It's the cause of everything. There were some presentations yesterday which -- and in the reports we have -- indicated that in the registry data, we're surprised by the low rate of reported alcohol and drug involvement. I think it was in the 20% range with about 20% unknown. If you break it out, there's another report in there that shows for physical child abuse, it's around 8% or 9% of drug use in physical abuse cases. That struck me because I'm aware of the registry data in the Navy and their rate is 8% involvement for child physical abuse, alcohol and drug abuse. See, the data are very, very similar. So, I certainly think it has an impact. It may have an impact on severe forms of abuse. Look for everyday abuse that occurs in disciplinary interaction. I'm not sure that the mother or the father ten minutes before had a drink of whiskey.

Social isolation and loneliness (see Figure 21). They had done studies and looked at, actually, frequency of contact. It isn't clear whether or not these people are really more isolated in terms of friends knocking on the door, or a professional visiting. It is very clear they don't use the resources. They don't ask the person back. Or if you tell them, here's a program. It is military and they can attend, they're likely not to attend.

David Wolfe's work shows that even if they do engage momentarily, they are more likely to drop out, more likely to quit. So, it may have to do with interpersonal skills and trust, et cetera. Support building is very important at the first stages of working with these individuals. More studies than you'll ever want to see. These are controlled studies.

Problematic parent/child interactions (see Figures 22 and 23). Yes, they have problems. I'm not going to go through all of those. I will summarize them for you, however (see Figures 24 and 25). If you're into behavioral approaches, this literature is actually the strongest. They interact less with their children overall. When they do interact, the parents display higher rates of negative parenting behaviors. That is, more verbal aggression, more negative physical aggression. According to some studies, about 10% of their interactions involve verbal or physical assault. Less than a fraction of 1% of the general populations interactions involve verbal/physical assault. So, it's more than a ten to one ratio.

However, notice that 90% of the time the abusive parent is not engaging in verbal and physical assault. So, is it simply a skill deficit? What are they doing the rest of the time? It could be a skill deficit in that they're doing something else, but they're inept at it, in trying to explain. But, what gets them to that 10%? More intrusive and interfering behaviors like on a puzzle completion task, more inconsistent behavior at least defines their children's behavior – provide less facilitation, less mutual engagement, less play, fewer simple instructions and less reasoning -- notice how specific this is -- less verbal and non-verbal instruction, less affection, fewer positive responses, less contingent praise for appropriate behavior.

We have a study that's coming out in December that we did in Spain -- home observations of parents. They weren't abusers. We controlled for education – disassembled the risk construct. The most robust finding was that most parents in the home situation, high risk parents, were more inconsistent in their reinforcement of pro-social behaviors. That's what was predicted by my colleague. I didn't predict it. She did. She thought the main differences in being inconsistent and disciplined for negative behaviors, for punishment, that the biggest difference is that the at-risk parent and the abusive parent are inconsistent in responding to pro-social behavior. Translated: I'm your little son. I bring you a flower. You're as likely to ignore it or hit me as hug me for it. That's what that inconsistency means. Her ideas, and she's doing some longitudinal analysis and tracking of these families, sequential analysis of in-home observations. She's hypothesizing that what will happen to these kids is they will stop doing pro-social things and do more negative things, which sets up a cycle. Then the parent will be more aversive trying to get control. That's her model of the course of the cycle. I was really surprised that the findings were so robust in such a highly controlled study. And again, in-home observations, about 30,000 individual observations.

Almost done. We often talk about these parents as having inadequate coping skills, generally (see Figure 26). Certainly, it seems from clinical evidence they do. But, if you carefully match groups -- if you go in and you take other, say, lower SES, poorly

educated families and look at their general coping skills, you don't always find the difference. There do seem to be some differences in terms of parental coping, but I'm not so sure that the overall coping is different in these folks.

Problems in the offenders (see Figure 27), relationships with own parents and family, the history of the abuse factor, although it's buffered by social support. And that's the final overhead -- next to the last, anyway.

Buffering factors (see Figure 28), one supportive parent during childhood. These are not all controlled studies. The Egeland study is a longitudinal study. Basically, social support tends to counteract, or countervail, if you will, and buffer the effects of an abuse history. Likewise, a peer relationship, therapy have been found to be supportive. So, offering social support is probably an effective intervention.

My first overhead. Well, the room is full of MDs, more than PhDs, so this is an appropriate discussion to engage in. The reason I'm putting this up is because of the ear of the gentleman. This is going to seem a little loose momentarily, but stick with me. You'll notice it's a middle-aged male and the ear is smooth. Two years ago in the New England Journal of Medicine there was a study that showed that if you're a middle-aged male and you have a deep crease in the ear lobe, you're seven and one-half times more likely to have a heart attack. And die or just have a heart attack?

PARTICIPANT: Just have a heart attack.

DR. MILNER: Just have a heart attack. So, seven-and-a-half times more likely --it's called "the cardiac crease". It has a name in the medical book, cardiac crease. It can be used in assessment. It's a risk factor. We talk about risk factors for physical abuse and treating risk factors. Well, here is a risk factor. What if I suggested that it's a risk factor. It's used for assessment. It's predictive. It has a great utility for prediction. Why don't we do ear lobe massage to get rid of that crease? Plastic surgery could make some money -- McDonald's-type ear lobe massage parlors. We laugh because it sounds silly. It sounds absurd. "What's Milner saying to us up there?" It's a marker variable. All of the factors that I showed you before, all those risk factors, may only be marker factors or they may be causal. We don't have enough evidence yet. People act as if we have evidence. We don't. So, when we pick some of those risk factors -- even I recommended some -- and also, we're not looking at interactions. We're treating them in a single variable, single cause, single result model which is wrong. When we go out and pick out four or five of those for our clinicians to treat, we may be doing ear lobe massage. They're marker variables. They're not causal. Not important links in the chain. They make sense. The reason we know this is absurd is because we know a lot about physiology. We have a broad background. We don't know much about physical abuse or even human behavior. And so, if something kind of logically makes sense, a risk factor marker was put on the list. I think this distinction is important because I think it's one reason why we haven't made more progress. There was some concern yesterday, or last evening when we showed the graph and showed there's been no change. We looked at national statistics

and there's very little change. I don't want to say no change, but very little change. It may be because the researchers like myself, the few that are left, really haven't answered the questions sufficiently for the clinicians to know where to intervene -- it's not that we should give up or be frustrated, but I think we should, in working with the people that we supervise, make clear to them that we're really not sure what we're doing sometimes. And that many of you are very frustrated and not see changes and it doesn't mean they're a bad clinician. – bad family advocacy clinician, it may be because we've told them to go work on these three factors and maybe those three factors aren't relevant to this Thank you.

CDR EMANUEL: Thank you, Joel. You have raised a lot of questions and challenges that we will be able to pursue during the discussion.

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(1988) THE APSAC ADVISOR
APSAC, 407 South Dearborn, Suite 130, Chicago, IL 60605

Figure 1.

Biological factors

- Physiological reactivity
- Neurological and neuropsychological factors
- Physical health problems

Figure 2.

Physiological Reactivity of Child Maltreating Parents and At-Risk Individuals to Child-Related and Non-Child-Related Stimuli

Groups	Stimuli	Authors
Maltreating parents		
M/F parents (A&N,C)	P-C Interaction	Disbrow, Doerr, & Caulfield (1977)
Mothers (A,N,C)	Child/Tone/WN	Friedrich, Tyler, & Clark (1985)
Mothers (A,C)	Child	Frodi & Lamb (1980)
Mothers (A,C)	P-C Interaction	Wolfe, Fairbank, Kelly, & Bradlyn (1983)
High- and Low-risk individuals		
Mothers	Four Non-C Stim	Casanova, Domanic, McCanne, & Milner (1992)
M/F students	Child	Crowe & Zeskind (1992)
Mar./Div. M/F adults	Child	Pruitt & Erickson (1985) (?)
Male students	Child/Alarm	Stasiewicz & Lisman (1989) (?)

Figure 3.

Neurological and Neuropsychological Factors in Child Maltreating Parents

Group	Design	Authors
Mothers (HR,LR)	2 X 2 group/stress condition	Nayak & Milner

Figure 4.

Physical Health Problems

Group	Findings	Authors
Mothers (A,C)	yes	Conger, Burgess, & Barrett (1979)
Mothers (A,2C's)	yes	Lahey, Conger, Atkeson, & Treiber (1984)
Mothers (A,C)	yes	Milner & Wimberley (1979, 1980)
Mothers (A,C)	yes	Milner (1989)

Figure 5.

Self-Esteer/Ego-Strength

Group	Findings	Authors
Mothers (A,C)	y, pers. worth	Melnick & Hurley (1969)
Mothers (A,C)	yes	Rosen (1978)
Mothers (A,C)	yes	Evans (1980)
Mothers (A,C)	mixed y, pers. worth n, self-esteem	Shorkey (1980)
Mothers (A,C)	y, pers. worth y, self-esteem	Shorkey & Armendariz (1985)
Mothers (HR) (long.)	yes	Brunnquell, Crichton, & Egeland, (1981)
Mothers (A,C)	yes	Perry, Wells, & Doran (1983)
Mothers (A,C)	yes	Oats & Forest (1985)
Mothers (A,N,C)	yes	Culp, Culp, Soulis, & Letts (1989)

Figure 6.

Perceptions of Children's Behavior

Group	Findings	Authors
Mothers (A,N,C)	no differences	Gaines, Sandgrund, Green, & Power (1978)
Maltreating parents	less social awareness	Newberger & Cook (1983)
Mothers (A,N,Prob.,C)	indirect evidence do not perceive infant cues	Crittenden (1981)
Mothers (A,HR,C)	faulty stimulus discrimination	Wood-Shuman and Cone (1986)

Figure 7.

Perceptions of Child (recognition of affective states)

Group	Findings	Authors
Mothers (A,C)	less skill in recognition of children's emotional expressions	Kropp & Haynes (1987)
Mothers (A,C)	no differences in recognition of children's emotional expressions	Camras, Ribordy, Hill, Martino, Spaccarelli, & Stefani (1988)
Mothers (A,C)	no differences in recognition of children's or adults, emotional expressions	During & McMahon (1991)

Figure 8.

Attributions

Group	Findings	Authors
Mothers (A,N,C)	yes (context) for I/S	Larrance & Twentyman (1983)
Mothers (A,N,C)	yes neg.intention	Bauer & Twentyman (1985)
Mothers (A,C)	external LOC	Wiehe (1986)
Mothers (A,3C's)	attri. blame to C for neg. inter. mixed for pos.	Bradley & Peters (1991)
Mothers (A,C)	no neg. intention and disposition	Rosenberg & Reppucci (1983)
Mothers (HR,LR)	no (trends)	Chilamkurti (1990)
Mothers (HR,LR)	attri. less compet	Diaz, Neal, & Vachio (1991)
Females (HR,LR)	mixed (context) no overall diff. yes w/mitigating information	Milner & Foody (1994)
Mothers (HR,LR)	more internal attri. for neg. beh. own child and other and other mother	Miller & Azar (1996)

Figure 9.

Evaluations of Children's Behavior

Group	Findings	Authors
Mothers (A,HR,C)	more neg. beh. (videos), even daily living scenes	Wood-Shuman & Cone (1986) (?)
Mothers (HR, LR)	overall behav. is more wrong and diff. by transgression (vignettes)	Chilamkurti & Milner (1993)
Mothers (HR, LR)	diff. by transgression (vignettes)	Casselles & Milner (1996)

Figure 10.

Group	Findings	Authors
A,N,AS,3C	mixed (lower)	Spinetta (1978)
Mothers (A,N,C)	no diff. retro.	Gaines, Sandgrund, Green, & Power (1978) (?)
Families (A,C)	no diff. retro.	Starr (1982)
Mothers (A,N,C)	more (negative vs. positive)	Larrance & Twentyman (1983)
Abusing fam M/F (A,C)	yes (slower dev.) M and F	Perry, Wells, & Doran (1983)
Mothers (A,C)	no diff. develop.	Kravitz & Driscoll (1983)
	mixed, no diff. in development diff. in exp. complex behav.	Azar, Robinson, Hekimian, & Twentyman (1984)
Mothers (A,C)	higher	Oates, Forrest, Peacock (1985) (?)
Mothers (A,C-spouse A)	unrealistic exp. differences	Azar (1986)
Mothers (A,C)	overest. devel. milestones	Williamson, Broduin, & Howe (1991)
Mothers (HR,LR)	yes higher and lower compliance (dep. on context)	Chilamkurti & Milner (1993)

Longitudinal studies		
Mothers	devel. expectations var. from norm in mal. parents	Egeland et al. (1979)
Mothers	low r between devel. knowledge and mal.	Altemeier et al. (1979)

Figure 11.

Rigid Expectations

Group	Findings	Authors
Abusers	yes	Milner & Wimberley (1979, 1980)
Abusers	yes	Milner (1989)
A,S,N,3C's	yes	Milner & Robertson (1990)
Abusers	yes	DePaul, Arruabarrena, & Milner (1991)

Figure 12.

Empathy

Group	Findings	Authors
Mothers (A,C)	yes	Melnick & Hurley (1969)
Mothers (A,C)	yes	Frodi & Lamb (1980)
Mothers (A,C)	yes	Gynn-Orenstein (1981)
Mothers (A,C)	yes	Letourneau (1981)
Mothers (A,C)	yes	Wiehe (1986)
Mothers (HR,LR)	mixed	Milner, Halsey, & Fultz (1995)

Figure 13.

Stress/Distress

Group	Findings	Authors
Life stress		
	mixed high in A but N highest	Gaines, Sandgrund, Green, & Power (1978)
	yes	Conger, Burgess, & Barrett (1978)
	no (retro)	Starr (1982)
	yes	Lawson & Hays (1989) (?)
Distress		
	yes	Milner & Wimberley (1979, 1980)
	yes	Rosenberg & Reppucci (1983)
	yes	Mash, Johnston, & Kovitz (1983)
	yes	Lahey, Conger, Atkeson, & Treiber (1984)
	yes	Milner (1989)
	yes	Milner & Robertson (1990)
	yes	Milner, Halsey, & Fultz (1995)
Stress	no diff. but A rep. more neg. impact (only overall not M/F)	Perry, Wells, & Doran (1983)
longitudinal studies		
Mothers	stress diff. adeq./inadeq care M	Egeland et al. (1980)
Mothers	stress sign. r with mal. risk	Altemeier et al. (1979)

Figure 14.

Disbrow, Doerr, & Caulfield (1977)

abusers and matched comparisons: no differences in use of physical and verbal directives in response to stressful scenes (parent-child interactions).

Lawson & Hays (1989)

couples (A,C) good match: no interaction between self-esteem and life stress

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Schellenbach, Monroe, & Merluzzi (1991)

as abuse potential increased, stress increased rejecting, punitive beh.

Nayak & Milner (unpublished)

Casselles & Milner (unpublished)

Valle & Milner (unpublished)

Dopke & Milner (unpublished)

Figure 15.

Negative Affectivity

Affect	Findings	Authors
Anxiety		
	yes	Aragona (1983)
	yes	Perry, Wells, & Doran (1983)
	yes	Lahey, Conger, Atkeson, & Treiber (1984)
Depression/Unhappiness/Sadness		
	yes	Milner & Wimberley (1979)
	yes	Evans (1980)
	yes	Frodi & Lamb (1980)
	yes	Milner & Wimberley (1980)
	yes	Lahey, Conger, Atkeson, & Treiber (1984)
	yes	Friedrich, Tyler, & Clark (1985)
	yes	Milner (1989)
	yes	Culp, Culp, Soulis, & Letts (1989)
	yes	Milner & Robertson (1990)
	yes	DePaul, Arruabarrena, & Milner (1991)
	yes	Milner, Halsey, & Fultz (1995)

Figure 16.

Negative Affectivity cont.

Group	Findings	Authors
Anger/hostility/aggression		
Mothers (A,C)	no chronic host.	Melnick & Hurley (1969)
A,N,AS,3C	yes	Spinetta (1978)
Mothers (A,C)	yes	Evans (1980)
Mothers (HR) (long.)	yes	Brunnquell, Crichton, & England (1981)
Mothers (A,C)	yes	Rosenberg & Reppucci (1983)
Mothers (A,4-dep,C)	yes	Susman, Trickett, Iannotti, Hollenback, & Zahn-Waxler (1985)
Mothers (Mal,HR,C)	yes	Lyons-Ruth, Connell, Zoll, & Stahl (1987)
Mothers (HR,LR)	mixed (context)	Milner, Halsey, & Fultz (1995)
Annoyed		
Mothers (A,C)	yes (C)	Frodi & Lamb (1980)
Mothers (A,N,C)	yes (C)	Bauer & Twentyman (1985)

Figure 17.

Psychopathology/Emotional problems

Group	Findings	Authors
Mothers (A,C)	yes/emotional prob.	Melnick & Hurley (1969)
Convicted abusers (C)	mixed/MMPI	Wright (1976)
Mothers (A,C)	yes/emotional prob.	Conger, Burgess, & Barrett (1979)
Abusers	mixed but concl. no diff. > chance personal adjustment	Starr (1982)
Mothers (A,N,C)	mixed/yes/MMPI	Friedrich, Tyler, & Clark (1985)
Mothers (A,C)	yes, emotional prob.	Oats, Forrest, & Peacock (1985)
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Mothers (HR)	lack of emotional stab. (best predictor of sub. maltreatment)	Pianta, Egeland, & Erickson (1989)

Figure 18.

Behavioral characteristics

- Alcohol and drug use
- Social isolation
- Problematic parent-child interactions
- Aversive parental disciplinary strategies
  - More power assertion (verbal/physical assault)
  - Less induction (talking/reasoning)
  - Less frequent use of rewards
- Inadequate coping skills

Figure 19.

Alcohol Use

Group	Findings	Authors
Male students (HR,LR)	yes	Stasiewicz & Lisman (1989)

Figure 20.

Social Isolation/Loneliness

Group	Findings	Authors
A,N,AS,3C	yes	Spinetta (1978)
Mothers (A,C)	yes	Evans (1980)
Mothers (A,C)	trend	Shorkey (1980)
Mothers (A,C)	yes	Shorkey & Armendariz (1985)
M/F Abusers (A,C)	yes	Milner & Wimberley (1979)
M/F Abusers (A,C)	yes	Milner & Wimberley (1980)
Mothers (A,C)	yes	Trickett & Susman (1988)
M/F Abusers (A,C)	yes	Milner (1989)
M/F Abusers (A,C)	yes	DePaul, Arruabarrena, & Milner (1991)

Figure 21.

Problematic Parent-Child Interactions

Group	Findings	Authors
Abusers	less communication, less facilitation	Disbrow, Doerr, & Caulfield (1977)
Abusers	mixed less positiven, no diff in rate of neg beh	Burgess & Conger (1978)
Abusers	no diff. punish, reward	Evans (1980)
Abusers	mixed less tactile and auditory stim, no diff visual contacts	Dietrich, Starr, & Kaplan (1980)
Abusers	less willing to interact less attentive more indifferent	Frodi & Lamb (1980)
Abusers	more aversive interactions	Reid, Taplin, & Lorber (1981)
Abusive fam	no differences (retro.)	Starr (1982)
Abusers	mixed more directive, no diff on ques, praise, neg, and no resp cat	Mash, Johnston, & Kovitz (1983)
Abusers	less social interaction less initiation, less verbal/nonverbal instr less affection, less play behavior no diff on verbal neg	Bousha & Twentyman (1984)
Abusers	less responsive to child's prosocial behavior	Lorber, Felton, & Reid (1984)
A,2C	more negative physical beh fewer positive parent beh	Lahey, Conger, Atkeson, & Treiber (1984)
A,4-dep,C	anxiety/guilt methods w/ authoritarian methods & low on rational guid lower on pos. affect inconsistent	Susman, Trickett, Iannotti, Hollenbeck, & Zahn-Waxler (1985)
Abusers	less overall behavior, less contingently praised app behavior	Schmidt & Eldridge (1986)
Abusers	more punitive, less reason and simple commands	Trickett & Kuczynski (1986)
Mal.,HR, C	more interfering behaviors inconsistent	Lyons-Ruth, Connell, Zoll, Stahl (1987)
Abusers	diff. disciplinary app	Trickett & Susman (1988)
HR,LR	more verb cont, less dist	Pharis, Neal & Vachio (1991)
HR,LR	more verbal and physical discipline, less induction	Chilamkurti & Milner (1993)
HR,LR	trend toward more power assertion, less induction	Milner & Foody (1994)
Abusers	less interact., more noncont. responses to prosocial beh	Cerezo, D'Ocon & Cerezo (1996)
HR,LR	more intrusions, less pos beh, more noncontingent responses to prosocial beh	Dolz, Cerezo, & Milner (1997)

Figure 22.

Problematic Parent-Child Interactions cont. (Attachment)

Group	Findings	Authors
A,C	attachment diff.	Browne & Saqi (1988)
HR,LR	attachment diff. at 12 but not at 18 months	Egeland & Sroufe (1981)
Mal.,HR,C	attachment diff.	Lyons-Ruth, Connell, Zoll, Stahl (1987)

Figure 23.

PHYSICALLY ABUSIVE, COMPARED TO NONABUSIVE, PARENTS:

1. interact less with their children
2. when they do interact parents display
   a. higher rates of negative parenting behaviors,
      more verbal aggression and
      more negative physical behaviors,
   b. more intrusive and interfering behaviors,
   c. more inconsistent behavior when responding to their children's behaviors,
   d. provide less facilitation,
   e. less mutual engagement,
   f. less play,
   g. fewer simple instructions and less reasoning,
   h. less verbal and nonverbal instruction,
   i. less affection,
   i. fewer positive responses,
   j. less contingent praise for appropriate behavior.

Figure 24.

Problematic Parent-Child Interactions (Summary)

Findings

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less interaction
less attentive

more negative behaviors, physical and verbal
fewer positive behaviors (rewards)

ratio of positive to total positive/negative

less induction (simple requests, reasoning)
but, more intrusive neutral behaviors

inconsistent responding
less responsive to prosocial behavior

less affection

Figure 25.

Inadequate Coping Skills

Group	Findings	Authors
Mothers (A,N,C)	no diff. in coping	Gaines, Sandgrund, Green, & Power (1978) (?)
Mothers (A/C)	irrational thoughts	Shorkey & Armendiariz (1985)
A,N,2C's	def. in prob. solving skills	Hansen, Pallotta, Tishelman, Conaway, & MacMillan (1989)

Figure 26.

Problems in Offenders' Relationships with Own Parents/Family

Group	Findings	Authors
A,N,AS,C	yes	Spinetta (1978)
A,C	yes	Oats, Forest, & Peacock (1985)
---		
longitudinal	yes	Hunter, Kilstrom, Kraybill, & Loda (1978)
longitudinal	yes	Herrenkohl, Herrenkohl, & Toedter (1983)
longitudinal	yes	Egeland, Jacobvitz, & Papatola (1987)
---		
review	30% (PA, SA, EN) - rate in well designed studies	Kaufman & Zigler (1987)
review	inconclusive	Widom (1989)

Figure 27.

Buffering Factors

Group	Findings	Authors
Mothers (HR)	one supportive parent during childhood	Hunter, Kilstrom, Kraybill, & Loda (1978)
Mothers (HR)	support from nonabusive adult during C, and supportive rel. during adulthood: friend, spouse therapist.	Egeland, Jacobvitz, & Sroufe (1988)
Mothers (A/hist, C/hist,C/no hist)	involved in satisfying relationships	Caliso & Milner (1992)

Figure 28.

Child Sexual Abuse

Malcolm Gordon, Ph.D.

Moderator: Raymond J. Emanuel, M.D.
CDR, MC, USN

CDR EMANUEL: Doctor Malcolm Gordon will talk about the trends in sexual abuse. Doctor Malcolm Gordon is a psychologist and in the Adult Trauma and Victimization Program of the Prevention, Early Intervention, and Epidemiology Research Branch of the National Institute of Mental Health. He is responsible for providing technical assistance to research grant applicants and for monitoring funded research projects in the area of child trauma, child abuse and neglect, family violence and adult trauma victimization. He received his PhD in psychology from Cornell.

DR. GORDON: My job is to rather quickly give you a brief overview about research on child sexual abuse. I work in the program that funds most of the research on child victimization and trauma at National Institute of Mental Health. We are one of the major sources of funding in this area, and we've been doing it for a long time.

My comment is going to be a very broad, brief overview about what I think the important issues are and what we have learned, and also what we don't know and some of my opinions about research in this field. In addition, I'll be citing a lot of unpublished research studies, which is somewhat unfortunate because you won't have a chance to judge for yourself the strength of these studies. Partly, it is because I think some of the more interesting data and results I am aware of come from studies that have not been published yet. Also, a lot of them fit into my biases which I'll make clear.

In our program, we fund research on the incidence and prevalence of childhood sexual abuse, on the characteristics of sexual abuse, both the episodes and the outcomes, on etiology and risk factors, and on the consequences. Particularly because we're a mental health funding agency, we focus on mental health consequences of childhood sexual abuse. Also, we fund research in treatment and prevention. Taking this body of studies, I want to address some questions about childhood abuse and try and give you some research evidence, along with my biases or opinions about these areas, too.

One question is, How common is sexual abuse? This has to do with the epidemiology of sexual abuse. Are there typical types of sexual abuse? What explains why sexual abuse occurs? What are typical consequences of sexual abuse? How varied are the outcomes of sexual abuse? Do we have effective treatments for victims of sexual abuse, or ways to prevent sexual abuse? I'm going to organize my discussion of research around these issues.

I will make some observations about the area of sexual abuse, particularly in comparison to other areas of child abuse research. Child sexual abuse is an area in which there is a lot of research. There's probably more research about sexual abuse than any other type of maltreatment by far. That's the good side. Unfortunately, the bad side is that most of the studies are not very well developed or not well done, with very small samples. One reason for that is that it's very easy -- I say that in quotes -- it is relatively easy to get clinical samples of sexually abused kids.

One reason for that is now, in most large jurisdictions, there are large assessment and treatment centers for sexually abused kids. For example, there's one in Los Angeles that sees about 1,000 kids a year. One disadvantage of that, of course, is that your samples are heavily skewed towards clinically referred kids, or kids who have been reported for sexual abuse. Of course, one of the reasons for that is the requirement for reporting the sexual abuse. I'm not sure I know of any study other than two telephone surveys that actually asked kids in the community, who are not necessarily reported, about their experience with sexual abuse.

When we were doing some preliminary work for a large epidemiological study of mental disorders in children and adolescents, one of the sites did a preliminary study asking very brief screening questions about types of abuse and how many cases they might have to report. The estimate was that somewhere around 5% to 7% of kids might have a reportable incident of either physical or sexual abuse. In a large epidemiological study, that's a huge number of kids. That's one of the limitations.

So, one question is, How common is sexual abuse? Again, there are a lot of small-scale studies of clinical populations of kids referred to clinics and so forth. Most of the research has been retrospective asking adults about their history of sexual abuse. There are some methodological problems with this whole area, as you might imagine. One is that people define sexual abuse in different terms.

Sexual abuse is also an interesting area because of the variation in who the offenders are. Generally, in the area of physical abuse and neglect, it's the primary caretaker who is the offender. So, that kind of narrows the field about perpetrator characteristics. Sexual abuse, depending on state laws, the researcher's experience, can range from any unwanted sexual contact of a child by an adult, older child, or peer to a more narrow concept of sexual contact by a caretaker. When you get non-caretakers, non-family members and other types of offenders, it's a very different type of psychology. A lot of times, this is lumped together all in one kind of pot which is somewhat different than other types of maltreatment.

Another big issue you get is disclosure. When you ask someone if they have been sexually abused, there's no guarantee they're going to tell you. We know there's a lot of under-reporting. We've had a couple of studies in which we've had researchers follow up samples of individuals that we know had indicated or substantiated sexual abuse in childhood, either from medical records or from actual protective service findings. A substantial portion of those individuals would not indicate that they were sexually abused in childhood.

Rape and child sexual abuse are probably the most unreported crimes. We know from some studies that when you ask adults whether or not they disclosed or reported this to anybody, particularly some authority figure or someone who could make an official report, that perhaps only five to 20% of adults in any type of study indicated that there was any attempt to disclose the abuse to anyone.

Another issue is how you collect information. This area, as opposed to a lot of other areas, seems pretty clear that the more intense your interview methods, and the more face-to-face interviews, the higher rate you're going to get. Despite all this, I think we have a pretty clear picture of the prevalence of sexual abuse in populations. Most studies find a range of about 20 to 30% of women, adult women, report an instance of significant contact, sexual abuse in childhood, at least one incident. Approximately 10% of males report this as well. We also know from a couple of studies that between 10 and 15 -- we've had several studies, but you get this same finding --between 10% and 15% of women and adolescents will report a completed rape before the age of 16. Several studies come right in that range of 10% to 15%. Some of those, however, would not be considered to be childhood sexual abuse because they're peer rapes.

You can estimate that, perhaps, between 1% and 3% of children a year experience sexual abuse in this country. That's not necessarily an incident in the classical epidemiological terms because it includes multiple kinds of repeat offenses. Also, a significant issue is that the incidence of sexual abuse is much higher in clinical samples, particularly women who present for mental health services. There are a lot of studies and they found a range of maybe 30% to 60% of women reporting for mental health treatment will have a history of childhood sexual abuse, even if they don't report that as having anything to do with their presenting symptoms.

Certainly, an issue is, Are there typical types of sexual abuse? I think this is an area in which we haven't made much progress. I think one of the reasons is the type of model that we use. Most people have taken the characteristics of sexual abuse like the frequencies, fear of the perpetrator, and treated it as something in Euclidian space, that these are all independent dimensions. We that there's a lot of clumping of characteristics so that, probably, a very complex typology is going to be more appropriate to understanding the characteristics of sexual abuse, both for treatment and prevention.

Most studies find that the modal age for sexual abuse is in the nine to 12 age range which is pre-pubertal. This makes sense. Generally, girls in this age range are more physically mature than younger children in terms of being a sexual object, but they have sexual naiveté and they're less likely to disclose. I think these are characteristics which makes them particularly a target for sexual abuse. I often tell people who are going to do either clinical studies or population studies that if you take ten, particularly low income girls in the age range of nine to 12, you're highly likely to find at least one girl that has an unreported case of contact sexual abuse in that group.

Typical perpetrators of girls who are sexually abused are a family friend, an extended family member, a more distant relative, a neighbor, an acquaintance. Familial sexual abuse in large-scale community samples definitely occurs in a minority of individuals. Intra-familial sexual abuse is much higher in clinical samples. For boys,

generally, it's much more likely that the offender is going to be a stranger or someone who is just remotely known by the boy.

There are cases of sexual abuse of pre-school children, as you're aware. It's a much lower incidence than with older ages, and it's much less likely to involve genital intercourse. Digital penetration is very common for very little kids. It's much more likely to be a non-family member in this age group. Again, we look at sexual abuse as compared to non-sexual abuse it's much more likely to start earlier, to be more repetitive, or chronic over a long period of time, to involve less threat and physical coercion, and to be progressive in terms of severity of sexual abuse acts.

What are the characteristics of sexual abuse? If you treat it as a global variable with global characteristics, we haven't gotten very far with that type of approach. I think the main reason for this is because there's a lot of confounding of the types of abuse that children experience and other types of characteristics. Not only the characteristics and the course of the abuse itself, but associated characteristics. I mean, I would think that an individual who sexually abuses -- and probably some of you if you work in this area, you've known some individuals who sexually abuse real little kids -- I think they have much more psychopathology than other individuals. There are also differences in family characteristics in incestuous and non-incestuous families. So, again, this is an area that we haven't had much enlightenment about. If you look at the literature about relating characteristics of abuse to outcome, it's a big mish-mash. Some people find frequency or severity important, while others don't. I think that this is one of the reasons for that.

Another issue that a researcher deals with is, Why does sexual abuse occur? I think a generalization we make is that it's like many other types of sexual victimization. It seems much more likely that sexual abuse is dependent on characteristics of the offender rather than of the victim. There are some characteristics of kids who are victimized that may put them at higher risk. For example, handicapped kids seem to be a higher risk, but basically, it's not a lot about characteristics of kids. It's much more the characteristics of the perpetrators that are predictive of sexual abuse. Like a lot of sexual assaults, child sexual abuse seems to be, to a large extent, a crime or a deviation related to opportunity.

You could look at different types of offenders. There's large literature on that. My colleague Jim Breiling, is an expert on pedophiles. This is another group of individuals who are basically sexually anti-social individuals, not necessarily exclusively focused on children. I think the recent news reports about the individual in New York with AIDS who is alleged to have had intercourse with hundreds of women and girls is probably an example of that type of individual.

There's another group which I think that we'll see more and more of. There's a group of families which seem to be highly anti-social and dysfunctional. They're the type of families that you see in a lot of different settings such as the criminal justice system, or

the child welfare services board that are at high risk for all types of deviant type behavior, delinquency and childhood sexual abuse.

So, some girls grow up in very anti-social, pathological kind of family environment in which sexual abuse is one type of deviant behavior, among many.

There's also some research on intrafamilial sexual abuse. Again, Joel Milner here would be one of the experts in the country. Many of you might be familiar with his Child Abuse Potential Inventory for trying to look at characteristics and screening for physical abuse. He has been conducting, over the last several years, a similar study trying to identify characteristics and screening of intrafamilial sexual abusers. I think he is also interested in perhaps extending that to non-familial sexual abusers.

I just might refer you to David Finkelhor's theoretical discussions about intrafamilial sexual abuse in terms of characteristics. He thinks there is some lack of bonding between the child and the father figure. This increases the risk of sexual abuse for the children in the service when there are deployments. Also, he would argue, that stepfathers play a role in that in many cases, they were not around when the victim was a young child. So, that there is less of a caretaker/parent role between the father and the child. Although this is not a highly significant finding -- you don't find huge differences, it seems to be a risk factor for children for sexual abuse. This is particularly relevant in the military.

Another issue in this area is -- and it's a sensitive issue -- what about the non-offending parent? This gets caught up in a lot of advocacy issues because primarily, the non-offending parent is going to be the mother. "Well, what was the mother doing when this was going on?" There are two sides to the issue. You will rarely find instances in which a mother aided and abetted sexual abuse by a boyfriend, father, or others. You get those in very small minority. You get more cases in which the mother either suspects or is aware of the abuse, but chooses to do nothing about it for various reasons, particularly dependency on the father.

In some cases, when you look at the girls who were sexually abused, most of the abuse occurred from relatives on the mother's side. A large portion of these women were sexually abused themselves in childhood. It was not an uncommon occurrence for these women to leave their children in the care of individuals who had a history of perpetration and even, in some cases, were the perpetrator against the mother themselves. So, this gets to an issue which you'll see in some studies on the long-term effects of sexual abuse, which is a lack of self-care. The mother herself might also play a role in monitoring or taking care of her children.

Maybe I'll just deal with two more issues here. One is, What are the typical consequences of sexual abuse? This is a complex area in which there has been a lot of research because of the clinical samples involved. Also, I'll mention a little bit about some treatment programs for victims of sexual abuse.

Basically, there are two types of consequences you see in sexual abuse. There is symptomatology, both acute and long-term that you see in children. This has been investigated both in terms of short-term effects in children and long-term effects in adults that present clinically. Now, interesting enough, there's much more research on the long-term effects of sexual abuse than acute studies of children who were sexually abused. There are two main, well designed studies that I know of. They're both pretty old now. One by Jon Conti and one by Tony Mannarino and Judy Cohen which looked at acute symptomatology in children who have been sexually abused. Again, these were referred kids who had been identified, but not necessarily in a clinical sample because they weren't necessarily presenting for treatment.

One thing you have to keep in mind is a lot of kids don't have much of a strong effect from sexual abuse. Despite the clinical importance of issues, maybe half of the kids, at least acutely and for follow-up periods, don't seem to have many effects or consequences from sexual abuse -- it doesn't seem to affect their functioning. The caveat for that is that we don't know much about delayed effects, both in terms of later development stages and adulthood. If you work in the trauma field, you're all the time finding individuals who are severely distressed by trauma, particularly in adults, but who are high functioning individuals.

When they're looking at symptomatology, what they find is that these kids have a whole range of symptoms. They have a lot more anxiety, depression, PTSD-type symptoms, and behavioral problems. These seem to be pretty strong after disclosure of abuse, but they decline over time so that they look much more like non-abused kids after a year except for a subgroup of individuals -- perhaps 20% or 30% -- who have high levels of symptomatology that just don't seem to decline. It's very similar to other trauma victims. You find a subgroup of trauma victims who have very high chronic symptomatology resulting from their trauma and exposure.

It's also interesting that the symptomatology that these kids experienced were between clinically referred kids, that were not necessarily referred for sexual abuse, but for other types of mental health problems, and control kids taken from the community. So, they look worse than kids you would find in schools, but they don't look quite as bad as kids that are specifically referred for clinical problems.

One type of symptomatology which has been found over and over again in studies of sexually abused kids, which is not so surprising, is the high rate of sexualized behaviors in these children. Particularly in the younger kids, you see more overt sexual behavior. Bill Friedrich has an instrument, the Sexual Behavior Inventory, which was one of the first instruments to assess markers of sexual behavior in children. It is used a lot by clinicians as an assessment device and a screening device because you find a very strong relationship between sexualized behavior and sexual abuse as a consequence.

I'm talking about two trends that are occurring now in the area of consequences of sexual abuse. One is the application of the trauma model to kids who are sexually abused. There have been great advances in this field such as Jon Conti's work. The question is, "If a kid has a sexual act with an adult, what actual effect does it have on the kid?" There are all types of effects it has on kids. It affects their development. It affects their associations, they withdraw, they are more depressed and anxious.

The PTSD approach has highlighted a certain group of symptoms which are more specific and related to a whole range of research on other types of traumatic experiences which has been a big boost. We can say, "Well, we understand something about actually what happens to kids who are sexually abused." Probably most of you are familiar with PTSD types of symptomatology so I really won't go into it.

How much PTSD do you find in kids who are sexually abused? Well, there are a lot of complications with that. I think many of you know that when you apply psychiatric criteria, clinicians very widely in how liberal or how conservative they are in applying these criteria. So, I have talked to a lot of clinicians about this and there have been some studies. The range that you'll see in referred kids who were sexually abused is from 10% to 60%.

I think there are some other problems with using the PTSD diagnosis with kids. One is that this is an adult diagnosis which is imposed upon kids. There are a lot of types of symptomatology you often see, particularly in sexually abused kids, which are not well covered by the current PTSD diagnostic criterion. One that you see often is regression in the development of kids who are sexually abused. Particularly little kids who will turn, let's say, to toileting problems and developmental tasks they met, that they had mastered, you see regression in development -- this is very common.

PTSD is a very evolving field itself. I know in adults one of the big issues is co-occurrence of PTSD and other disorders. So one question is, "Is there more than one type of PTSD?" So, for example, the people who work a lot with combat veterans, which is the class of individuals which has the longest history of investigation of PTSD, a big issue now is in relation to PTSD and co-occurring depression and substance abuse disorder. Are the combat veterans who have depression different from the ones that just have PTSD? What about substance abuse?

I might just briefly mention one other area because it's very hot in trauma research in general, and it's also now being applied to children. This is biological consequences of traumatic events. Okay, this has evolved from the adult literature where they have found consistent biological differences in individuals with chronic PTSD versus people with acute PTSD or say, combat veterans who didn't develop PTSD.

One of the biological systems that has been looked at are the sympathetic nervous system, which might account for arousal type of symptoms in individuals. The second system is a stress response system, the hypothalamic/ pituitary/ adrenal axis. The body

responds to the use of cortisol as a stress activation system which also has very complex effects in various areas of the brain.

The third area in which there is much less research is the pain endogenous opioid system which might have a relationship to analgesia, anhedonia, and the self-mutilation behavior that you often see in victims of sexual abuse. This research is now being applied to children. Again, preliminary results find, in some sense, similar results as in adults, but differences, too. So, for example, the strongest study we have now is being conducted by Frank Putnam, and many of you probably have heard about his doing this. It is a longitudinal study of girls who were sexually abused during pre-puberty and following up with biological measures and behavioral measures. It's one of the most well developed studies we've had about the long-term consequences of sexual abuse.

Interesting enough, he argues strongly that one of the negative effects that you're going to see in severely traumatized kids, and again, the trauma he's looking at is sexual abuse, is that these biological systems can be dysregulated early in development and then they have a profound effect on the further development of both biological and psychological systems in kids. In other words, their not only biological, but their psychological development is disrupted by this traumatic event. Interesting enough, he finds as in adult research, there's been kind of a common finding that cortisol system in traumatized adults with chronic PTSD seems to be under-activated which was somewhat surprising to people. In kids, he seems to find that it's over-activated. It could be that what happens is an initial over-activation. The biological systems attempt to compensate by dampening down responses to the hyperactivation of these systems so that later on you'll see individuals who have under-reactive systems because of initial hyper-reactivity to the systems. This is very complex research here.

Finally, I just will talk briefly about some intervention studies that are currently going on which I think are somewhat promising. Currently, there is a lot of intervention for kids who are sexually abused. It's somewhat ironic that in most major settings, that if a kid is sexually abused, he/she is likely to receive services right away, which is not true of other kids who are involved in other types of abuse.

The most common type of intervention is remove the perpetrator, one way or the other, particularly in intrafamilial types situations. In the intrafamilial situation, let's say if it's the father or the stepfather, he's kicked out of the house. This occurs at a high rate. If that doesn't seem feasible, the child will be removed. But very commonly, it's the perpetrator who is removed.

This has significant economic consequences for the family. In fact, Frank Putnam in his study found that one of the predictors of girls not doing very well who were sexually abused was whether or not their disclosure was voluntary or not. The girls who made a voluntary disclosure tended to do worse than the ones where the abuse was discovered by someone, that the girl didn't volunteer the information. He thinks the reason for that was because if a girl did disclose and then the perpetrator gets in trouble,

gets kicked out of the house and there's economic consequences and so forth, then there's a blaming orientation for the kid because she caused this. Whereas, if the girl is not responsible for the reporting, then there's less of that type of blaming individually.

I think there are some promising clinical approaches that we're supporting that are focused on sexually abused girls who have PTSD. I didn't mention in terms of moderating effects on the consequences, but one of the strongest ones is the reaction of the supportive adults, particularly the non-offending parent towards the kid in terms of disclosure and her reaction to the child, and the instance of abuse. This is a very difficult clinical area because many of the non-offending parents have a lot of guilt about this situation, confusion, mixed feelings if they have a dependency or a love relationship with the offender and so forth like that.

It has been recognized that the reaction of this non-offending parent is a very strong component of how well kids do in terms of coping with their experience of sexual abuse. So, the types of models we're seeing now, more developed clinically, provide treatment both for the non-offending parent to deal with her reaction to the sexual abuse and trying to get her to provide support to the child and also treatment of the kid for the mental health consequences of sexual abuse. Studies that we're supporting, again, are focused on PTSD types of symptomatology in these girls.

We just started funding a two-site study by two of the top clinicians in this area, Esther Demliger who is at the Medical University of New Jersey and Judey Cohen who is at Allegheny University of Pennsylvania, Allegheny Hospital in Pittsburgh who are applying a trauma-focused, brief treatment to girls. They've had some promising preliminary results in terms of the effects of this treatment. This combines two types of approaches to trauma treatment. One is exposure-based treatment where the individual basically discloses, particularly from multiple types of abuse, serious or disturbing instances of sexual abuse and gradually, over time, basically unfolds the story. In a safe setting, it gets the child to be able to tolerate, to take the feelings and the thoughts and the images associated with the abuse. So, this is exposure-based treatment.

The other component is a cognitive processing treatment which deals with the child's attributions about the abuse: who is at fault, why it happened, and so forth like that because that's a common characteristic, particularly in younger children. You see a lot of distortions about their beliefs about why the abuse occurred, their role in it, the role of other individuals, the consequences of it and so forth. Both of these treatments are basically treatments that have been shown to be very promising with rape victims and are being used for children who were sexually abused.

CDR. EMANUEL: Doctor Gordon, we'll look forward to the exchange of information within the clinicians and the researchers, family advocate folks in this area.

NIH Overview of Child Abuse and Neglect Research

Peter S. Jensen, M.D.

Moderator: Raymond J. Emanuel, M.D.
CDR, MC, USN

CDR EMANUEL: Doctor Peter Jensen is going to give an overview of the research at NIH in child abuse and neglect and the direction of future research. Doctor Jensen is a fellow graduate of GW. His current position is the Associate Director of Children's Research at the National Institute of Mental Health. He's also the Chief of the Developmental Psychopathology Research Branch and a guest scientist at the Walter Reed Army Institute of Research. He has numerous other positions on advisory boards, editorships and publications and awards, almost too numerous to mention.

DR. JENSEN: Great. Well, it's a pleasure to be here. What I'm going to describe are the efforts of a work group at NIH. While Malcolm has carried the lion's share of the child abuse and neglect research within NIH, there are some components of research in some of the other Institutes, including the National Institute of Child Health and Human Development, the Neurology Institute, the Dental Institute, the Institute of Nursing, et cetera (Figure 1).

In response to a congressional request about a year ago (Figure 2), year-and-a-half ago, that was really stimulated by advocacy groups, like the National Association of Social Workers, National Child Abuse Coalition, the American Psychological Society, and other groups, both Appropriations Committees in the Senate and the House turned to NIH and said, "Look, we don't think you're doing enough in this area. We want you to review all of what you're doing and make a report back to us." And so, these Institutes then were asked to respond to that and then my function was to carry this trend-setting NIH working group (Figure 3) as we tried to respond to the congressional requests as well as to outline a plan, a strategic plan, across NIH in terms of what we ought to be doing and what we will do in the child abuse and neglect area.

So, initially, we began meeting last year. We've added other Institutes to this group since that time. We decided rather than reinvent the wheel, we would turn to some of the existing research, including the very lengthy report done by the National Academy of Sciences (NAS) on Understanding Child Abuse and Neglect (Figure 4). That report came out in 1993 and it basically identified 17 priority areas. Thirteen of them which were research-focused where there were particular research needs, and four additional areas where they had more to do with policy recommendations. Part of that IOM or NAS report also indicated there was really a need for more national leadership. I think there was some frustration that NCCAN was charged with all of this responsibility, but had relatively few resources.

So, for a variety of reasons, perhaps other federal agencies weren't taking the appropriate initiative and leadership in this area. So, while there had been efforts across other parts of the government to coordinate efforts, NIH, per se, had not done its own job in terms of, as the Germans say, "Sweep in front of your own door." It hadn't really taken care of its own shop and it was, if you will, one of these sideliner, back-burner issues. That was really, I think, a helpful report, but even that report alone didn't really get us out of the trenches and get us out on track and really begin looking at the issues. It really

wasn't until we had this mandate coming from Congress that we began to look at this. So, we used that report, if you will, as a statement of the research needs.

We've heard some very elegant summaries of both the child physical abuse and sexual abuse research this morning. Now, what we did across all of the involved NIH Institutes was then to take those 13 areas of research priorities and look at what had taken place over the next, really, four to five years because it takes several years to put one of these reports together. So, we actually had four to five years of additional research we could look at and say, "In these 13 priority areas, how well are we doing? How well have we done?"

So, what we did is, we used one of our little systems that code all research (Figure 5). We looked at all the current NIH research and we found that there was, in terms of our coding system, research that focused primarily on child abuse and neglect and research where at least one of the aims was focused on child abuse and neglect, $33 million. Often, you may have one aim out of seven or eight other parts of the project. It might be five, 10, 15 percent of the overall project. If you look actually at what we are doing specifically on child abuse and neglect, it's a much smaller figure, $23 million in actual fact.

Now, one of the major recommendations of the report was that a lot of knowledge about the antecedents and consequences of the abuse and neglect needed to be examined. As we looked at that broader area, you can imagine all kinds of -- well, we were talking about poverty in terms of antecedents, or mobility, or community disruptions, et cetera. There's all kinds of research on antecedents and a lot of good basic research on parent/child relations, for example, that is relevant to child abuse and neglect research. That actually has a very substantial research base, another $48 million that has a lot of that basic research that feeds into the child abuse and neglect area.

In the same way, there's a fair amount of research looking at the consequences of abuse and neglect in terms of studies of children with conduct disorder or PTSD. So, we have a fair amount of research on the antecedents and consequences. So, in sum total, we're talking about some $82 million. But again, only $10 million really, specifically, looking at the child abuse and neglect area.

Now, we reviewed some of the reasons why research hadn't really progressed in this area. I think the first thing that we decided was that NIH, as a research institute, needed to take the mindset that child abuse and neglect is a biomedical trauma. It's not a social problem. It's not a problem with -- it's that as well, but it's a health problem. It is a health problem affecting our children and families. And so, it's too easy in a biomedical institute to, you know, carve the world into this is ours and this is theirs. So, we took a very strong and clear position. This is our responsibility. This is a health problem and this is a health research institute.

Nonetheless, there are a lot of difficulties, I think, that this group is well aware of that have made it quite difficult for child abuse and neglect research. Everything from difficulties with the assessment procedures, difficulties with the definition and differences from jurisdiction to jurisdiction, to problems with the limited amounts of funds. Nonetheless, we felt that there were some significant research gaps that we wanted to prioritize that we wanted to put money into the next few years. We identified three areas. That's down here under research gaps (Figure 6).

The first is intervention research. I think Malcolm and Doctor Milner alluded to the fact that we really have very little knowledge of effective interventions, whether a good preventive intervention for high risk groups, a good intervention for those that may be first time or second time situations. So, there's very little we actually can say we know works at this point. While we have things that are promising, we've been promising a lot for a long time. We haven't really delivered at this point. The problem, I think you've seen it from the other day, is apparently one that continues to expand. So, intervention is a critical area.

The second issue has to do with developing reliable and good measures and definitional statements on what constitutes physical abuse, sexual abuse, neglect, and emotional abuse. These things can be very muddy, murky territories. So, one of the things a trans-NIH working group, or actually, a trans-NCCAN interagency working group that Malcolm co-chairs, has done is to host several workshops on coming up with better definitional standards and assessment tools.

So, we planned on hosting a conference in that area, probably a series of conferences to try to further nail this down. So, the conference this coming year, I think, is in March? So, that's one of the areas that is actually underway, but we expect to see more action in that area.

The third area of research emphasis that we felt really had been neglected was neglect. I think there's a lot of concern that neglect itself may be as or perhaps even potentially more harmful in many ways than physical or sexual abuse, certainly than physical abuse. This is an area that we have not devoted a lot of time and attention to. So, these were the three areas that we are going to put a priority on in the next few years.

Now, we can't do that very effectively at all, given where the research infrastructure is now without attending to the problems that Joel alluded to, namely the very small cadre of investigators that are out there currently. And so, for example, to be competitive for an NIH research grant -- right now, if you say, "I want to have a research career. I want to get training. I want to get one of the NIH Standard Research Awards, an RSDA, a Research Scientist Development Award." Well, to do that and to be successful at it, you have to have a mentor.

As it is now, you could not get a mentor except by calling up someone 1,000 miles away because there are so darn few of them. The way the study sections treat that

is, they say, "Ah, you know, not very feasible. You know, nice, but who can really mentor long distance?" And so, yes, there's a real need, but maybe what this person really needs to do is move to where the mentor is, or something like that. So, in a way, when you have a very fragile infrastructure, getting it up and going is a real major problem.

So, one of the other things that we are doing is looking at developing mechanisms that will allow both a combination of long distance mentoring and actually pairing investigators, promising young investigators, with mentors and to bring promising people in and put them through, if you will, a series of three or four repeated exposures with mentors with the goal in this process, after three or four years at NIH, to develop the RO1 or the K Award, or whatever it be with a special mechanism that looks for that.

So, we're going to train them up in the state-of-the-art assessment issues and all the clinical and research issues, to do research in this population, to expose them to such matters three or four times. Then, when they've gotten that, have them hit the street with a PA or a program announcement, or a request for applications. That will greet them at the same time they're coming out of the chutes.

Now, the other thing that we are doing -- and we're just beginning this process – is we're identifying (if you go back to that $82 million), we're going back and scanning all the people who are doing research that's related to child abuse and neglect. Most of them aren't doing that research, as you know. So, what we're going to do is we're going to bring in those peripheral researchers with the attempt to entice them more directly into the child abuse and neglect area. So, that will also be this coming this spring where we'll be hosting workshops with established investigators. Probably, also, we'll bring some of the new investigators in at the same time, the want-to-bes and the potential mentors and begin this process of building the infrastructure to be greeted at the end of that one-and-a-half to two year process by dollars that, hopefully, we'll corral together through Justice and NIH and maybe the Department of Defense. Actually, we had a meeting about a month ago and John Newby was there, where we met with Justice, DoD, and NCCAN representatives and others who are involved in this area. So, these are some of the plans.

I think there are some really extraordinary opportunities in the Army, in particular. I served on the FACMT and I had marvelous experiences in those settings. I was very impressed with the many strengths in military settings. I think, if we put together the right investigators with the right settings, there are some remarkable opportunities in the military setting.

What you said last night in terms of you felt like NIH didn't have any money, I would disagree. I'd say we do have money because you have, I think, potentially some research opportunities, but it's a competitive world. If you have some research opportunities, I don't think they can be matched in other settings - let me just go through the list I made here this morning.

You have relatively uniform assessment standards for child abuse and neglect set by, I assume, Army regulations. It doesn't mean whether the county calls it abuse and neglect, but what you call it. So, you have relatively uniform assessment procedures and identification procedures.

For good or ill, you have four effects on neglect. There's probably, in terms of what was shown last night by Ed McCarroll, less neglect per se because there's this minimum SES that everybody's got a job, at least. There's these other resources. So, neglect may or may not be a good thing to study in the military, but it might in some sense.

You have better screening procedures, it seems to me, and you have other screening programs you can bring to bear on identifying high risk populations, the EFM program, for example. You have, potentially, in terms of Joel Milner's presentation, of these ecological models, you have a better handle on critical ecological variables. You have SES, if you will, and you can use rank as a proxy for that.

You have standard housing when we're talking about people on base. It reminds me of a study I did when I was at Fort Gordon. Basically, we did a post survey and we looked at two different housing aggregates. I was quite interested in the housing areas where -- and I was interested in your comments about social support -- housing areas where they were all in a cul-de-sac, facing each other with kind of a, you know, central play area. These were set up in little pockets, lovely, wonderful, creative natural social structure. Versus the other area with long streets that wound round and round and round. They had kind of a sense of anonymity.

I was quite fascinated, given equal rank structures in the two housing areas, to find much higher abuse -- somewhat higher abuse, but certainly higher alcohol and many other reports to the Provost Marshal in this anonymous area than in these very integrated supportive environments where families have five or six neighbors and they all knew each other. They faced each other. The kids played in the interior courtyard, et cetera. There was one way in and one way out. I mean, it was very interesting. Many fewer referrals to ADAPCP, the alcohol and drug program, in that area as well.

You have access to special populations. For example, active duty mothers with stay-at-home dads. That is an interesting group to look at. Or dual active duty parents under certain kinds of stress during deployments, et cetera. You have access to other records where you can link with appropriate command support, hospital data, ADAPCP data, FACMT data, Provost Marshal data – I mean, that's really an amazing thing -- social group system data, et cetera. You have a large system that you have control over where you could put an intervention in one area and not another area. And so, you could potentially randomize interventions. Incredible opportunities. You have this appropriate command support. You just could not do this anywhere else.

You have the ability to standardize training procedures by regulation, by fiat. Say, "This is how we train in our place." You get the DPCMTs and the Deputy for Community -- whatever he was called, I can't remember the name of the guy anymore, I've been out so long. But he has all those programs under him. DPCA, thank you, yes. You know, you can say, "This is how we train on our post. This is how we train and this is the program we'll do. This is how we're going to train our intervenors." You have, potentially, the chance to work with the Provost Marshal so they work as a partner. That's a particular kind of approach that you wouldn't have in -- I mean, where else could you get the Chief of Police, to work cooperatively in these kinds of things.

You have these other ecological supports. You have it on base. You know, that's a remarkable kind of context. You have geographic proximity. You have spouse support groups that are there. Then you have incredible recurring natural experiments. We call them deployments. It's just a gold mine of opportunity where many of the other variables that can't be controlled under other segments could be examined if the political will and the research imagination came together to work on these issues.

The cons are, obviously -- one of the cons I always saw in the military -- is there was always this generous use of all these unproven interventions. You know, the people come around and they'd hock these interventions. They'd hit my book and it's great, and then everybody who had spouse abuse or child abuse had to run to this 14 session course. No data, other than it looks good, and it cost a lot. It was great if you had the contract.

I guess there's always some concern about the generalizability argument. You know, I think that's really the red herring and I think we ought to get past it. I've been writing about this for a long time. I mean, basically, I think the people in the Army and the Navy and the Air Force share most of the same genes as the rest of the civilized world, even the uncivilized world. So, I think that while those are important concerns, I think that there are research opportunities here that really can't be passed over.

I think one of the other problems in the Army, and perhaps the other services, is that there's often only a punitive response to sexual abuse. You know, and then the guy is off to Leavenworth. That was my experience. I don't know if that's still the case. And so, you know, without good cooperation from the command channels about what gets prosecuted and to set up some model programs, if you don't work it from the top, it could be a problem. Then you have the problem of getting booted from the Army. How can you study a family that's been booted? You know, the dad is down in Leavenworth and the family is now moved. It's pretty difficult to study all of that.

The last area I would say that would be very intriguing to do in the Army is to look at the possibility of policy changes. Think of policy as a research intervention. I'm not sure which one, a few just crossed my mind. What if you went into certain day care centers at the policy levels and said, "We need to do this." You know, look at the impact and the stress on families in those first few years of life. You probably couldn't get rates

of abuse, per se, out of that, but you could certainly look at some of the approximate variables.

COL MAYS: I want to make sure I clarify that. I don't know the exact age category. I do know those are the situations presented in cases I've examined, so that the age may be different in the military and civilian setting. Potty-training is more-or-less the consistent requirement.

DR. JENSEN: Yes, yes. That's very interesting.

COL MAYS: I didn't want to go on the record as saying the Army forces children to be potty-trained, but it is the regulation.

If I could mention, we did find one study, an analogy that seemed fairly consistent where men who thought they were good at handling puppies and dogs did fairly well at potty-training. They could teach you the same techniques with some of the children. I found that to be true.

DR. JENSEN: Very interesting.

Well, it seems to me that at the policy level, certain types of things for, say, deployed parents that might be pursued more systematically. The Army had visiting community health nurses. I don't know if they still have them. They did five years ago.

PARTICIPANT: We still do.

DR. JENSEN: But the ability to visit and to intervene was a remarkable thing. The thing that could be done even with existing resources is to look more strategically at some policy changes at these kinds of levels, or parent training for high risk parents. Maybe some of these things are already going on, but institute certain things even base-wide with a real push and then look at the differences.

Thank you.

CDR EMANUEL: Thank you, Peter.

We're going to take a break from 10:00 to 10:30. During the break, if people can think about what Peter was talking about in terms of how do we apply the research to what needs to happen in the military and in the Army specifically, in terms of identification, interventions, and outcome studies. So, if you can start to think about that. That will be what the main thrust of the discussion and the rest of the day will be.

Thank you.

NIH RESEARCH ON CHILD ABUSE AND NEGLECT: CURRENT STATUS AND FUTURE PLANS

National Institute of Health
National Institute of Mental Health (lead)
National Institute of Child Health and Human Development
National Institute on Drug Abuse
National Institute of Nursing Research
Office of Behavioral and Social Science Research

Figure 1.

The Senate and House Appropriations Committees requested that the NIH:

"... convene a working group made up of representatives of its component organizations currently supporting research on child abuse and neglect. The Committee further encourages the working group to hold a conference on child abuse and neglect to assess the state-of-the-science and make recommendations for a research agenda in this field, and include in this conference relevant outside organizations and experts in the field. The Committee requests that this working group be prepared to report on current NIH efforts in this area, the accomplishments of that research, and on plans for future coordinated efforts at NIH at the fiscal year 1998 hearings."

Figure 2.

ACTIVITIES OF THE NIH CHILD ABUSE AND NEGLECT WORKING GROUP (CANWG)

- **Monthly meetings**
- **Identify accomplishments and future research needs**
- **Coordinate child abuse-related research across NIH**
- **Establish relationships and coordinate its activities with other sectors of government**
-

Figure 3.

NATIONAL ACADEMY OF SCIENCES REPORT "UNDERSTANDING CHILD ABUSE AND NEGLECT"

- **Child maltreatment research across the federal government often proceeds in a "haphazard, piecemeal fashion**

- **Better national leadership needed to organize and develop the research base**

- **17 research priority areas**

  - **better understanding of the nature and scope of child maltreatment**
  - **increased knowledge about the origins and consequences of abuse and neglect**
  - **improving treatments and prevention interventions**
  - **developing a science policy for research on child maltreatment**

Figure 4.

REVIEW OF NIH MALTREATMENT RESEARCH

All current NIH research

- **research primarily focused on child abuse and neglect**
- **additional research related to causes and consequences**

$33.7 million devoted primarily to child abuse and neglect

- **million devoted exclusively to CAN**
- **million is focussed on CAN as one of several major objectives**

$48 million of additional research is relevant to understanding the precursors and consequences of abuse and neglect, although not focused on child maltreatment per se

$82 million on research primarily or secondarily related to child abuse and neglect

Other NIH Institutes: NINDS, NIDCD, NIDR, NCI

Figure 5.

CHALLENGES AND OPPORTUNITIES

Conflict between guarantees of confidentiality in research vs. legal and ethical requirements to report suspected maltreatment

Legal limbo re: informed consent/assent of children in foster care

Funding services via block grants may increase difficulty accessing populations

Need to ensure that referral guidelines for assignment of CAN across NIH are sufficient

Research gaps

- **definition, identification, assessment of child abuse**
- **child neglect**
- **intervention research**

Research infrastructure and research dissemination

- **role of state agencies in supporting, disseminating, and utilizing empirical research**
- **work with agencies to disseminate findings to "real world" settings**
- **shortage of investigators trained to study child abuse**
- **few mentors qualified in interdisciplinary research**

Figure 6.

Child Abuse and Neglect Research Discussion

Moderator: James E. McCarroll, Ph.D.

DR. McCARROLL: I think we'll get going again. I'd like to introduce those participants who arrived late. Can we start with you, Jim?

DR. BREILING: Jim Breiling from NIMH. Actually, both Malcolm Gordon and I are now called the Prevention, Early Intervention, and Epidemiology Research Branch.

DR. McCARROLL: Then Al Brewster.

LtCol BREWSTER: I'm Al Brewster. In a former life, I was the Director of the Research for the Air Force Family Advocacy Program. Now I've got a terrific job over at Andrews Air Force Base teaching family practice residents research and helping to sensitize them to the issues that we discuss these days.

DR. McCARROLL: Thank you, Al.

LTC BRANNEN: I'm Steve Brannen. I'm the Director of Research for the Department of Family Medicine here at the Uniformed Services University.

COL SOUTH-PAUL: Hi. I'm Jeanette South-Paul, Chair of the Department of Family Medicine here at USUHS.

LTC BRIETZKE: Steve Brietzke, faculty, Department of Medicine at Uniformed Services [USUHS].

DR. McCARROLL: I think we couldn't have had a better ending for the morning session than Peter's remarks about the importance of the Army, as a place for research. Certainly, it was interesting to hear your pros and cons. This is section of the program in which we hope to hear from everyone on the topics that were brought up this morning by Doctors Milner, Jensen, and Gordon. Does someone want to start out with either a comment or a question? Our purpose, of course, is to formulate a research agenda for the Army.

COL SOUTH-PAUL: A comment that I wanted to make was that as I listened to a number of the presentations this morning, it seemed clear that a lot of the work has been done in already clinically identified populations, children and/or families where they were referred by a clinician for obvious abuse of some kind, or obvious problems. It seemed to me as if it wasn't as clear what the denominator was because there are a lot of folks who haven't been referred who maybe are identified later on. What I would request is that some attention be given to working with those of us who are primary care providers who don't work in this area, who find it a very uncomfortable area to work in and may not have been as aware of what are the risk factors, who are the more likely perpetrators of child abuse and/or neglect which has been raised this morning? What are the things that the primary care provider should keep in mind? Then what is the next step? Because even though we know what to do when there's an obvious case, what if it's not so obvious? Wouldn't it be better to find it at age 10 or 12, than in an adult at age 25 who is

having major problems, post-traumatic stress disorder or whatever? So, I would suggest that even though it's much harder to get a handle on, that we start looking at the clinical avenues whereby folks are more likely to access the system. You have folks who are not working full-time in this area and who need a little bit more information or need to be encouraged to be more willing to focus on this area. We've all heard about it in medical school and residency training, but that doesn't mean we get our continuing medical education or continuing nursing education or in that area.

DR. McCARROLL: Response from someone on what's being done?

Maj LAWRENCE: Well, I'd say that's been an area of mine that I just looked at with an Air Force study looking at pediatricians, family practitioners, and emergency physicians, at their amount of training with Steve Brannen back there. We looked at child maltreatment training in residency and afterwards. I just want to echo what Jeanette was saying. In our study, we found that there is just a lack of training and a lack of understanding by our primary care providers. We didn't find a lot of striking differences between specialties like we had thought we would. I feel that has been a very neglected area in my training and support. I notice that, too, when I go to conferences on family violence or violence research, there's just so little directed at the medical provider. I think it's a very important avenue where we can make a difference in what we're doing. We're probably not easy people to work with and probably a lot of them don't want to hear from you, but I think that they need to hear about this issue and they need to wake up and learn more about it.

We also did a study looking at training in US medical schools on child maltreatment to see what schools had up-to-date training. It has really just been recently. I can tell you, too, for emergency medicine that domestic violence training has just become a requirement in our core curriculum for training our residents in the past few years. When I was a resident, I never once had a lecture on domestic violence. It was just not a topic you learned about. We all knew back in the '80s that it was going on, but it was not something that was discussed. So, we're way behind, physicians are, in appreciating the significance of this issue. I talk to physicians about this and try to get more training into residency programs and medical schools. You can have all the treatment programs in the world, but what good are all these great treatment programs if you're not identifying your victims? So, that's part of the reason I'm here -- I'd like to see if there's not a way identify these victims.

MS. JOHNSON: As an Army policy, we have tried to make multi-disciplinary training available for all the disciplines that have a very primary role in family advocacy. At some levels, we have centralized that training because we considered that a particular discipline needed it more than others. In the case of training physicians and health care professionals, we have delegated or relegated that to the installation level. It's generally the social work office or the family advocacy program manager that is supposed to make that training happen. It is much more difficult to pull physicians away from their place of duty and bring them to a central location than it is for some of the other professionals,

although they are eligible to attend the family advocacy staff training course that's held in San Antonio. For instance, we pay for a full week of training for law enforcement personnel in handling child abuse cases, as well as domestic violence, even to the extent of simulating a crime scene. We actually had them restore a home down at Fort McClellan where we do that training. We've also trained lawyers because they're the folks who advise. We could certainly move that up on the priority list, but that falls, in my mind, less into the research area and more into the education and training area.

COL MAYS: If I could comment? We might also be experiencing, I guess, the phenomena of cyclical emphasis on training our physicians in the medical community. About ten years ago there was a great emphasis on this. A protocol was prepared by Health Services Command for such training. It had anatomical drawings and directive procedures for medical personnel to follow. It was signed by then the Chief of Clinical Operations. What we experienced though were some providers who were apprehensive about even suggesting the allegation, particularly in spouse abuse, that there might be an issue. They wanted to avoid things related to court. So, if you looked at, I think it's the DD 558 form in the emergency room, there would be all of the physical or diagnostic manifestations of abuse and then the person was discharged to the home, or discharged wherever, return to clinic, but, perhaps not that referral to the appropriate family advocacy resources group. This was particularly the case if the victim said "I don't want the authorities notified." So, in terms of taking the available research that we have, perhaps it's time now to institutionalize the way we do this training. There is a requirement in the Joint Commission of Accreditation of Health Care Organizations for the institution to be able to identify child, spouse, and elder abuse, as well as sexual assault victims. So, if we're going to stay credentialed by that particular institution, we need to make sure we work on that. So, we'll take this one on to the boss, at least our Surgeon General.

Maj LAWRENCE: I think there is an avenue for research in this, too, because so often in education, we just say, "Oh, well, okay. We're the experts. We've looked at the research. We think this is what they need to know." We throw out these programs that are maybe not the most effective for our target audience. We just decide that there's to be a certain type of program. One of my issues with this whole thing is what do they need in their training? What is a good avenue of training? Is it one hour a year that they go to a class? You know, a lot of times, I think we're missing the issues because it may not be only identifying physical abuse or sexual abuse. I find when I do a lot of lecturing on this, there is ignorance of what happens in the system about how are these people treated. What happens in our FAST [Family Advocacy Staff Training] programs? I'm amazed at how ignorant a lot of physicians are about the whole process. My guess is that is why there's a great reluctance on physicians' part. That's just anecdotal. I don't have anything to prove it. But, I would encourage us, if we do look at developing programs, that we also look at studying their effect and impact. This is a great body to do that with because, in a sense, our physicians are a captive audience.

COL LOCKETT: If I could just pick up on that. There was a study, I believe, done in New Mexico where physicians were given a number of additional questions to ask family members when they presented for care in the emergency room or for primary care. That study showed that by just asking certain questions, such as by asking a female spouse, "Did your husband hit you? Were you hit? Is this scar possibly from an injury?", the incidence of reporting went up significantly without a great deal of knowledge and understanding of the process -- just giving them things to look for and asking the questions. Perhaps one of the possible research projects would be in our emergency rooms among primary care physicians, simply asking a couple of more questions as part of their assessment when someone presents.

DR. BREILING: The program I came into at NIMH had a real concern with utilization and dissemination, not just to have things on the books. The bottom line -- just to build on this excellent suggestion -- is that we found that once you have the knowledge, it is ten times more difficult to get it implemented well than it was to originally do it. Actually, this is the case in industry. We have one scientist, ten engineers, and 100 salespeople to get it out and to get it implemented. Let me tell you what things don't work. Research articles don't work. The average readership is one-and-a-half persons, beginning with the author's family.

I'll give you a practical illustration as well. A lodge for mentally ill people was developed, a program that looked pretty good. They thought this would be great to disseminate. So, when they sent out the research articles and looked at the adoptions -- four percent of the people got it. When they developed a workbook with detailed procedures and sent that out, the adoption rate went up to 16%. When they responded to requests and went out and worked at the site, the adoptions went up to 67%. Which really says something about how you're going to have to proceed. Now, the fidelity, once adopted, was zilch. We discovered this with a teaching family group model which Father Flanagan's Boys Town now uses. It's the only social service model in the country, in the world, that has procedures in effect to assure high fidelity on a performance base. It's beautiful. It brings tears to your eyes because here are kids that in other facilities would be miserable. Because of the high quality and the high care, the turnaround that you see takes place. The initial efforts by classroom instruction models were all failures. It took ten times more work in research to get that fidelity up than it did to do the original work.

So, I really want to just underline, as a major thrust, it does no good at all to have the basic knowledge unless you follow through. Talking and workshops are not going to do it. You have to work at the site. You have to get data. And you have to have the quality control fidelity checks that we use regularly in medicine: tissue culture, quality control procedures, and so forth to implement and follow through and illuminate the resistance and problems and difficulties and resolve them. That is an area that you can make a really major contribution for well being, but it will not be simple. It will be very difficult and challenging, but extremely important.

DR. McCARROLL: Thank you, Jim.

DR. URSANO: Jim, by fidelity, you mean actual carrying through with the program?

DR. BREILING: Following the original model. The typical thing is to say "Hey, we've got a good model. This is the most researched delinquency model in the world." They did a masters program. One year, all the classroom instruction, the graduates went out, got jobs. Those were the worst programs ever and every single one of them was fired within five months from the group. So, they said, "We don't know how to train these people." They went back. What they did was a completely different track. It's a one-week workshop. It's followed through on the job with around-the-clock consultation and performance-based measures, working with people. To get it accredited, every year, you have to get high ratings from the kids in the home, from the parents, from the schools, the social service people, the board of directors, and demonstrate all the skills in an on-site observation. The training sites are evaluated and accredited based on the performance of the homes within their network. That's like medicine. They don't do it on degrees. You do it on the outcomes in good part. That works.

DR. URSANO: One of the mechanisms, following on Peter's comments, is that we have mechanisms for implementing this, and if I could broaden it, I think the question of education programs and research on education doesn't just apply to physicians. It applies across all our providers. The question is, What are the outcomes and what, in fact, happens? The question becomes, Is there also a way to incorporate something into policy in its implication? In a discussion we recently had, we proposed that. similar to an environmental impact statement, there be a cohesion impact statement on all new personnel policies. Every personnel policy had to address the question of the impacts of that personnel change on cohesion. If one can get a requirement inside the hospital, inside the utilization review procedures done in the emergency room, that included in the checklist , How often have issues of child abuse been explored in the history taking? then one is attacking the problem from multiple directions. Then one could begin to see the development of a programmatic approach -- to see whether or not by implementing both education and policy changes, one increases the identification rate in multiple areas in police as well as in hospital settings.

DR. McCARROLL: Malcolm?

DR. GORDON: This issue about physician involvement in areas of domestic violence and child abuse is an important one because, as you know, a lot of times this is the entree into the system for kids who are physically abused. Most kids who are either physically or sexually abused go through a physician at some point during the process. So, it's important. I think that there are significant barriers for the role of physicians in this area. I have what I call "the 20 percent rule." I'm almost facetious about it, but I see this in a lot of studies injuries which are related to domestic violence or child abuse. About 20 percent, for example, of pediatric burns seem to be due to child abuse. About 20 percent of child head injuries seem to be due to child abuse. About 20 percent of women supposedly go to emergency rooms in urban hospitals because of domestic violence.

I think this is one area in which there's an expectation that physicians deal with the social context where the patients are coming from. There are a lot of other areas of medicine where this is true, too. For example, I know that a big issue in AIDS research was with the three drug treatment cocktail. Since a high percentage of AIDS patients are inner city minority patients, one of the concerns is that they don't follow through on the protocol very rigorously. If you're going to half-treat the AIDS that these patients have, it is going to lead to more virulent forms of the virus which is a very real public health danger. So, in medicine, there is a lot of follow-up. In most types of medicine, physicians don't necessarily focus very much on the social context that the patients are coming and are leaving.

One of my best examples is a recent handbook of head trauma. It's 1,500 pages. In that whole book, it only has about two paragraphs that deal with child abuse. Basically, the point of view is that child abuse, like the emergency room physician or the pediatrician report, is that, "We don't get involved in that." Most neurologists don't necessarily care how that injury came about, but they want to treat the injury. They don't want to deal with all this outside. Now, partly, it might be a personality thing because some people are really sensitive to this area and it's important in community medicine. But, I think if you're in the area and you're a concerned physician, say, in an emergency setting, and you see a kid come in who has been sexually abused, you report it. You only have to go through a couple of cases in which you're brought into court and there is a very contentious legal battle before you start questioning, "Well, I'm not getting paid enough to do this. It's taking a huge amount of my time. You know, do I want to do this a lot?"

There are some people who are dedicated in this area who do it a lot. We were interested in funding a project which was dealing with helping health personnel in a clinic-based HMO system identify further services for women who were victims of domestic violence. They went into an intensive treatment program with workshops. The program seemed to be going well, but the problem they ran into is that there was a change in the way the state dealt with Medicaid patients. They went to a capitation basis. So, all of the HMOs were competing for these heads. Because Medicaid patients generally tend to be sicker and more expensive, that built up a caseload for Medicaid to start cutting costs all over the place. So, one of the problems was that the medical personnel in the clinic setting no longer had the time to devote to the domestic violence identification program. It was a change in kind of the context in which they operate and that was a problem. I tend to think that physicians can play an important role in identification, referral, and screening, but not alone. I think that they have to be part of a system in which referrals are pretty much closely linked with what the physician is doing.

DR. URSANO: Let me interrupt for a minute.

DR. GORDON: Sure.

DR. URSANO: I think many of the things you're describing are exactly the strength of that kind of activity in the military. In other words, there is a system available that is available through referral for treatment that doesn't require the physician directly. Secondly, we are engaged in treatment of patients from different populations. Thirdly, the reimbursement of the physician is not dependent on how many patients they see. So, for many reasons, there are advantages. I agree, however, with your overall thrust that physicians tend to not want to get involved with this. That's why I want to broaden this discussion because it's not a question of physician education. The question is research on education.

There is another group that we have in the military that I'll bet civilians would give their eye teeth to educate -- the mayor of every city -- to be able to bring in the mayor of your city and have them meet together as a group of 10, 12, 15 mayors and talk about child abuse in your community. Are you aware of it? How much does it happen? How much of it do you want to change? It's a unique opportunity for an educational research paradigm. And whether or not one could see changes in communities through educating the leaders is a very unique question to bring up. I agree with your thrust in terms of that and I just wanted to get us to a broader question in this rather than honing to the narrow one.

DR. GORDON: Well, may I make one caveat on that. I think the linkage is important because it affects motivation. The physician refers people to social services and then he doesn't know what happens. This person disappears.

DR. URSANO: Sure, and this would be in the design of the study.

DR. GORDON: So, the linkages are important between the physician and the patient services.

DR. URSANO: Right. What was going on between these agencies during this time? This type of thing doesn't happen by saying "Make it happen. Go over it with the checklist." But, I think that's a design question.

DR. McCARROLL: Al?

LtCol BREWSTER: Yes. As I've been sitting here listening to these comments, there have been a couple of themes that have reminded me of a situation in on an Air Force Base. I was the family advocacy officer there and we had a horrible case of a spouse death. It was awful. The hospital commander had to go out, the physician had to go out and determine that she was dead. It was very traumatic for him. I was called into his office and a 558, an emergency room form, was slid underneath my nose. I was asked if I would have identified this person and referred this person for spouse abuse. The 558 simply indicated that the woman came in and had her index finger crushed. She was sent home with aspirin and ice. The source of the injury was her husband. That had happened a month or two before her demise. Well, not being politically astute at the time, I said

"No, I wouldn't have sent that on to be referred, that 558." The hospital commander looked at me and said, "Well, you're going to have an opportunity to find out because I want you to review every 558 that comes through the emergency room from here on out until I leave this hospital command."

So, initially, I was very upset and angry. I thought,"My god, what am I going to do? I mean, I have to come in early and review every 558 that's come through the emergency room." I went and told my staff and they were all in a huff about it. But, I started doing it and I marched smartly and did it. The net result on that was that at the end of one year of doing that, our referrals from the emergency room had more than doubled. There was a tremendous network of understanding between the nurses, techs, the emergency room physicians and myself. There was constant education going on. I was there every morning. They had my coffee waiting for me. I reviewed and initialed every 558 that came through there. If there was something that was questionable, I went to the doc and said, "How did this kid get hit with a baseball bat? Who was on the other end of it?" Those types of questions increased the consciousness and enhanced the system. So, I'm just trying to bring together in a real life example some of the themes that have been talked about. That's a policy change that was instituted at that particular facility.

MS. JOHNSON: In 1989, the Department of Defense, either by direction of Congress or some horrific situation, actually commissioned a study on emergency room and health care delivery in family violence. The study essentially said what all of us know -- that our emergency room physicians and technicians were not familiar with or did not know about child abuse and were not making the appropriate referrals. I have to say that that was prior to my time of getting to Headquarters, Department of Army. I think what you're saying is that we need to re-emphasize in a policy direction what needs to happen in that area. That's not to diminish the necessity of this kind of training.

The American Medical Association has developed a number of very good training tools and curricula that we probably need to put our hands on and make available to our staff so that it is standardized. I think at different locations, like across any service, there are hospital teams that work extremely well either because of a tragedy or just because someone was enlightened enough to make it happen. At other places, it's hit and miss. The first step in trying to standardize that training is to make sure we've got a training package that people can use and adapt. I guess I just would not want to see us repeat and use what very, very limited resources we're going to have to redo the stuff that we found out in the DoD and all the civilian studies -- that it is very critical to train emergency room and first responders across the board. That information is there. It's very clear. It's also very clear, based on some of the American Medical Association materials, what needs to be taught. I sit on a committee on the American Bar Association Commission on Domestic Violence. They've talked about their emphasis on putting curricula in medical schools and making on family violence and domestic violence a number one priority. I guess I'm just concerned that we can address this issue with the resources that

we have available by heightening our attention to it and building linkages with some of the national organizations.

DR. URSANO: It might be one to solicit resources from the Surgeon General.

MS. JOHNSON: Right.

LTC BRANNEN: Ed, I've got a couple of comments. One of the things that the USUHS Department of Family Medicine is tasked with is to provide education and training around the world for CME and GME. Following up on what Delores was talking about, there was an identified need to educate physicians in the identification and management. I've been privileged to go on training teams to Europe, to the Far East, to Central America to train up primary care physicians in those arenas. Universally, the comment that we get is that the primary care physician is not exactly sure what their role is. Despite all the training we've done, they're still not sure what their role is. They confuse identification and referral with responsibility. Physicians, by their training, are taught to become responsible for patient care. There's a misunderstanding in our system that they believe that they are going to have total responsibility for the treatment, not just the identification and referral.

To tie that in with something that Linda and I found, only 70% of physicians endorsed referring to the Family Advocacy Case Management Team cases that they believed were child abuse. I believe that was one of our significant findings. Thirty percent of cases identified by that physician would not be referred by that physician to the Family Advocacy Case Management Team. So, I think there are some needs, but I think one of the biggest things that we need to be looking at is to continue training the physicians. I'm not going to pick on physicians as a group. I see them as being the king pin to the whole process. Not the social workers or the psychologists, but the physicians and the primary care providers including the family nurse practitioner, to train them in exactly what their role is. I've run Family Advocacy Case Management Teams at several different bases and I have the most difficulty getting physicians as a group, other than pediatricians, to come to my meetings. Even though they are tasked to be at the meeting, I can only get pediatricians to come. I don't know what other people's experiences are, but I would suggest that may be a lack of training on what their roles and responsibilities are.

DR. McCARROLL: One more comment. Let me ask you to think about this. Maybe one more comment on the issue of physician involvement, but I would like to see us go into the other areas that we have not covered. We had a lot of issues on the agenda last night such as age, of race, of type of abuse and neglect, and a lot of other things that we want to discuss. Not to discourage anyone's comments on the physician issue, but I think we've got a tremendous amount of ground here to cover and an opportunity to do that. Can you lead us on there, Peter?

DR. JENSEN: Well, yes. I mean, I'm troubled, too, by the direction we're going because it seems to me you want to distinguish here between clinical needs (and there are a lot of clinical needs) and the research and knowledge needs. What I'm not hearing is enough focus around the research and knowledge needs. I would encourage you maybe to think at the level of what are the policy needs of the Army and how might policy needs and research needs come together in a unique way that might only be done --certain questions, that as I think Bob Ursano said last night, might be very useful not just for the Army, but for the health of the nation. Because there are unique opportunities in this setting for research that will be found nowhere else. The clinical needs are everywhere, but it wasn't my understanding that was the purpose of this conference.

DR. McCARROLL: Right. Thank you. Now, let's go on to the Army research --I think one of the questions we had -- let me maybe steer things in sort of a radically different direction. There are two representatives here from AFIP. One of the things we frequently don't hear about in the clinical audience is child deaths because most of us are victim-oriented. In fact, the registry was set up to be victim oriented. So, in fact, many of those FACMT or CRC cases that I have heard reviewed when there's a death, there's no discussion. Can you all enlighten us a little bit about what you see from the issue of child deaths in child abuse cases and what your perspective is, and what your research objectives would be, and maybe what some of the impediments are? As I said last night, we saw in 1995, there were nine child deaths listed in the Army Central Registry. It seems to me we know very little about people in the Army who kill their children, either on purpose or accidentally.

CDR LAPA: Well, I think first, we see mostly infant deaths. The deaths we see are primarily in infants and things like shaken baby syndrome. I see a significant number of cases where I have great concerns about how the investigation was conducted, how the autopsy was done, the lack of a thorough medical/legal investigation, but there's really nothing I can do other than express my concerns. Like you can kill an infant without any physical signs and there's occult suffocation is always something that we're concerned with. It's kind of a controversial issue in the forensic pathology community, but a lot of people believe that this happens a lot more than we're aware of. We, of course, don't really get much into the family issues. We get the investigation report. Most of our cases we deal with are consultation cases. They're not primary cases where we actually perform the autopsy and participate up front in the medical/legal investigation. But we do often get an investigative report and we always read that. You know, we make observations but we don't do any research in terms of the behavioral aspects of those because we are obviously looking at it at the end of the line.

DR. URSANO: There are a couple of things that I jotted down that a commander would say. We have real impediments. We also have opportunities to deal with some of the topics. When I talk to a commander about an issue of child abuse, the most likely thing he's going to say is, "Throw the idiot out. I don't want him in my command. Get rid of him." Now, what research agenda should we have to be able to aid in that question? Is that correct? Is that a fact and should we say, "Go for it. Throw him out"? I can tell you,

no matter what our research says, in certain times, you won't be able to change that. But, in other times you will, when there's a conservation of force. Who should we throw out? You can't do that in the civilian community. We can. Which people should we decide to throw out and which people should we decide to keep? On what basis are we going to say that? Similarly, the other side of that coin shows up. "He's a good guy. He couldn't possibly have done that." If he or she works in the office of the commander, that's what you're going to hear. I heard a discussion, as we were talking yesterday and today, about alcohol. The type of comment that you are likely to hear from a commander is, "He's a drinker. That's the problem. Fix his drinking. We won't have this problem anymore." Is that true or not? Should we advise the commander of something different?

It was fascinating that someone mentioned that Joel had an evaluation for physical child abuse, potential abusers. As best I know, we don't have a standardized evaluation form that's completed throughout our system. Would it aid us in any way to be collecting systematic information on all abusers, even though it would have great limits? In other words, it would not be collected in the same form as you would in your laboratory, having trained everyone thoroughly. But, if I were a clinician, I would like data that indicates such information as, this person tends to externalize, this person tends to blame, and there is conflict in this marriage. It would be helpful if there were a check-off form that would aid us in thinking about the potential interventions that could be done at the post? Would it aid us in thinking about whether or not the interventions are happening the way we'd like them to happen? It seems to me these are research questions. They have research agendas accompanying them that answer down-to-earth problems.

MS. JOHNSON: Let me be even more specific. Several things have troubled me. I'm a policy person. I'm the person who writes the language that tells people what to do. There are several problem areas, in the Army in particular. One is that it is possible that our physical abuse cases are double what the civilian sector is. Why is that? What can anybody tell me about why that is so? If that is true, then we have a huge problem in the military. Are we somehow self-selecting people who have some kind of predisposition to more aggression. Are the majority of those people who are abusing their children physically the active duty members? That is extremely troubling, if true. That's what I need this group to help advise on.

We also have an over-representation of minorities in the military. On every scale of abuse, minorities are over-represented to a disproportionate degree. Are our police somehow inadvertently or consciously arresting more minority people when they arrive at their homes? Or is it just kind of a fluke? I mean, these are questions that we could ask. These are the questions to which that commanders want to know the answers. They cannot be answered unless we set up some kind of laboratory to get at these issues. The field is too evolved for us to continue to give simplistic answers to these questions. We are much beyond that, even with our own commanders. We're much beyond just saying, "That's the nature of violence and we have to learn to live with that."

We have a huge category of neglect and I don't have any sense of the stratification of that neglect. I can eliminate a bunch of it if I eliminate the category of unattended children. Perhaps that focuses us on the definitions. Perhaps the Army and all of DoD need to get to a point of saying, We are going to raise our threshold of abuse. But I need scientific data that says that that is, in fact, that is the right thing to do and that I'm not going to do more harm if I eliminate this category of parents that we're now catching and watching and coddling. They may do fine leaving their kids. I know that in my civilian community, a parent is not going to come to the attention of child protective services if they leave their child unattended and go into the post office. It's not going to happen. They may get a citation from the local police, but that doesn't necessarily trigger the child protective services to do something. It certainly does in our community.

The other notion is whether a platform of aggression exists in the military, What is our responsibility as an organization to the civilian community? If you follow the domestic violence literature, what happens is that a lot of the civilian offenders have some history of military service. That puts us in the proverbial catch 22. We don't have answers. We have wonderful opportunities to create labs in our communities. We have large enough populations at some of our posts to do some really good things.

DR. THOMAS: One item to study is the new SPAM [spouse abuse manual] which all the CRCs [case review committees] have been trained to use. It is very well defined, presumably will be filled out, and it relates to Peter's discussion about standardization of definitions, and what's going to be substantiated and what is not. It is probably not going to be uniformly implemented. You could have control sites and implementation sites start collecting data to see how people are following through the decision making process of the CRC. You could match that against recidivists and link that information with the Central Registry. I know there that there is some discussion about developing an equivalent child abuse manual and that would lead you to think about how you want to redefine maybe some levels of abuse. Ed, can you correct me? Last night you were saying that the physical abuse, that most of it is minor.

DR. McCARROLL: Right.

DR. THOMAS: So, that really ties into what you're saying. What I hear when I've sat in CRC meetings listening to people discuss substantiating cases.

COL LOCKETT: Well, that's right. One of the questions that is always asked is, "Are we better than or worse than...?" We work as hard and put almost as much effort into every case regardless of the severity. Some of that may change with the SPAM and when the child abuse one is done. Now, clearly, our experience suggests that the state, county, and/or local child protection services would not begin to touch some of the cases that we get involved in that take a lot of our time and energy and effort. So, it looks like from a commander's point of view, or from the leadership's point of view, that we do have this overwhelming problem in child abuse. This would be a reasonable study that would help shape policy, particularly if you use the same model with the levels and decide that these

we really can handle them differently. We can make different decisions about them and certainly, in terms of resources, do not have to use as many resources as we do in others. We could take a couple of our installations, small and medium, where we have different agreements with the county and just look at what we're handling versus what they're handling -- what are their guidelines for physical abuse cases and what would they be involved with versus what we're involved with because we take so many cases that they would not.

DR. THOMAS: And you have the inside-outside gate populations too. Not everybody is living inside the gate.

COL LOCKETT: Right. We take the cases that the state declines routinely. They don't even touch them. The county doesn't even want them. That's the minor problem. We don't even need to deal with that. That's a phone call. So, a study to look at a couple of our installations where we could compare the parameters of what, really, is described as physical abuse that really needs a certain kind of intervention versus what others do and other locales do.

DR. JENSEN: I was thinking, Ed, last night in your presentation that you were saying in your extrapolation from the data sets, it was like six versus 13 or 18 or something. It was quite a bit lower in the military I thought you were showing.

DR. McCARROLL: That's true, but those numbers were unadjusted.

DR. JENSEN: So, it would be unfair to say physical abuse is much higher in the military. It just means of those that end up with this category, it's proportionately more. But remember, just by virtue of SES, there's so much less poverty in the military that neglect and a lot of other things, by virtue of those experiences, would have to be less. So, I would think this is a bad message to put out. We don't want to fall into that trap that it's more in the military. I don't know that there's any support for that.

DR. McCARROLL: No, we don't. The purpose of last night's numbers were just to orient the audience and as a point of discussion and not putting that forward as truth.

DR. JENSEN: Right. But still, I don't think the data support the idea that there's more physical abuse in the military. It raises a question. It seems to me that the question of military versus civilian rates is not a very interesting research question. That's a political question. The commanders get worried about it and the press is interested in it, but you would never get a federal agency to fund that question. But the question of what works, there, the federal agencies would be very interested in funding the question. So, if you think about the interface of policy and research, I would go back to, How do you prevent? We don't know that. Or in work with high risk groups, How do you clinically intervene effectively? Are there policy manipulations that could be done that would have a dramatic impact on community levels of all kinds of problems, including that? How do you screen the perpetrators and what do you do with them? Do you throw them in, throw

them out? I mean, those are all questions that have a policy edge and a research edge that we're in the dark on. It would be great if an organization like this with the expertise and the political and policy venues into installations could pull it together.

COL LOCKETT: Let me just piggyback on that again, reframe that just a bit. I'm not really concerned about whether our rates are higher than their rates. I would be more concerned about, or interested in, looking at the parameters of definition. If I was not clear, I'm not concerned about being able to say, "We're less than they are," or, "We have fewer cases than they have," or, "They have more than we have." Is the difference that gets presented because the parameters are so broad in the Army, in this case, and more narrowly defined in the civilian community? What happens with those cases that are more narrowly defined and excluded or handled in a different way than what we would do with them because we have such broad parameters? What really happens, looking at the difference in terms of definitions, of what really gets intervention and what does not and what's the difference? What really happens to those cases in the local child protective service that would get attention in the Army or the same kind of attention, but would not in the community? That's the issue and not so much that our rate is a little lower than theirs. I'm more concerned about those definitions and parameters, using the resources more effectively, making better decisions about where to apply those resources. What interventions would really make sense if you don't have such a broad range of what your call abuse like the military does?

DR. JENSEN: I'd just encourage you to frame it as a research question. That's my point. It's an interesting question, but I'd just encourage you to move into developing new knowledge.

DR. URSANO: I think the example, David and Peter, might be with the word neglect -- to operationalize the question of unattended children and to examine the outcomes. What is the effect of being unattended? What are the effects of different types of neglect? Which ones have negative outcomes and therefore need more attention? Which ones don't have such negative outcomes and yet we are still classifying them in a way that drives our administrative system? What are those types of outcomes? That's the even more interesting question -- how those outcomes might differ by the type of neglect that's present. I also wanted to highlight one of the other things that Delores brought up. It's an interesting opportunity which is the idea of should we create certain laboratories or posts that, in fact, become centers of excellence, spots where programs are systematically examined or have the opportunity to be systematically examined because you have a particular group that you've educated over time to be sensitive to this topic.

DR. BREILING: Several things on identification. We'll never get it all officially because a lot of these cases never come to light. Something that does work, but is in the early stage are public education campaigns for self-referral and early treatment. Believe it or not, a lot of child molesters voluntarily come in for treatment. Gene Abel had this in New York City for ten years. Over 350 people with no legal constraint at all volunteered for treatment. Some had done atrocious things. "Stop it Now," which Fran Henry has

organized has started to make it national to extend this. Already in Vermont, with a limited number of ads, they have had 27 people come in to enter the justice system and treatment for child molestation. So, people will come in. It's in an early state of development.

A lot of work is needed. It's a way to expand the net and do something here. There's an opportunity there. This also relates to child sexual abuse prevention. We mentioned earlier about all these little cottage and district curricula. This area is loaded with programs with no demonstrated effectiveness that I'm aware of. When you look at the modus operandi and the sophistication of the child molesters and how they work, there's no reason to assume they would. Is there a role that the services can develop that can be more effective and more promising?

The third point I want to make has to do with junk data. The field is littered with it. Because there's data does not mean it's worth analyzing. A lot of this you can tell ahead of time. I would suggest that a lot of the comparisons that people are talking about -- don't do it. It is garbage. For example, to compare the child abuse rates when you've got differences of systems and reporting stuff, it's garbage. When resources are limited, it should not be done.

Let me take the black on white issue in terms of crime and the propensity to indicate what you need to do. We have a good handle on this in the delinquency and criminality area, very good. Issue number one: do the police arrest blacks more than whites? The answer is, Yes. How is this known? Well, it is known because we have a highly reliable, self-report measure of offenders and offenses. When you compare black and white kids who have reported the same number of offenses, lo and behold, the arrest rates for blacks are markedly higher. So, we do have evidence for that. Now, the next question is, Does that account for all the difference? What's the propensity or the likelihood of engaging in it? Are blacks or whites more prone to engage in violence? Let's use the criterion of engaging ever in adolescence in a serious violent offense. Controlling for SES in a neighborhood with males, there is very little difference in the proportion who ever engage in a serious violent offense. For females, it's different. It's a real one. But, we'll concentrate on males, because that's where the big problem is. Now, does this mean that if propensity is roughly equal that there's something more going on down the line? No, arrest records are different. There is another factor. It has to do with career length. Blacks have a markedly longer career lengths than whites. The longer you continue in anti-social behavior, the more varied and extensive and serious your offending gets. So, lo and behold, it is not a surprise that blacks wind up with far more charges and convictions for serious offenses given the career lengths. Now, what does this mean for the services to go along with the next step? Are you going to have equal black/white ratios in the services, for example? The answer is, No, you are not! I think the propensity is the same, controlling for SES in neighborhoods. However, unfortunately right now, we have far more blacks born from poor, single mothers who are at high risk -- Julius Wilson documents this right and left. You can predict bad outcomes, I'm sad to say, for low income urban areas. We're going to have this and the services are

going to draw this disproportionately. So, you're going to have more out of the same group that are going to be likely to engage in the offending. That does not mean that inherently there is a racial difference in male propensity. It means you're more likely to have kids with that propensity and that they're more likely to have longer career lengths, most of which is not detected. Eighty percent of serious, long-term violent juveniles are never arrested. So, by the conventional methods, you're not going to screen them out of the service. So, I'm just giving you an example. If you get into this, draw on every discipline's knowledge base and deal with adequate sophistication so we don't have wasted resources which are very finite and they confuse and complicate the issues.

DR. McCARROLL: Thank you, Jim.

Maj LAWRENCE: Joel talked about individual characteristics and factors. I think that's an area that we haven't really talked about this morning. When we're talking about the Army or the military, I guess I think of community. I like to think of the Army environment, or the military environment we live in. I live in a different community than our civilian people. I don't hear any talk about looking at research. It's kind of like, Well, these people were bad before they came into the military, so let's look at individual characteristics as a way to identify them. But you know, a lot of that does play into it, but I think that we're overlooking what may be more important than we've given it credit for. What community factors do we have? You know, it's usually said, that people tend to self-select themselves out by the kind of job they have in the Army based on their personalities. But, you know, is there an offset that's going on in this type of discipline that they're working in that is also creating some of the factors that are contributing to what's going on in the home? I just wonder if there's not some avenue to look into that. Why not look at some of these factors and the way we make our system work.

DR. McCARROLL: Al?

LtCol BREWSTER: I'd like to piggyback on what Linda is saying. I'll challenge Jim on something here in a minute. A couple of points. One, on infant death in the military and risk factors associated with it, in a nutshell, the article that Joel co-authored with me and several others will be coming out in February in Child Abuse and Neglect. We investigated 32 cases of infant maltreatment death. We did come up with some risk factors that feed into the whole idea of preventing that type of behavior in building healthier communities. Now, here's where I kind of take on Doctor Breiling. NCCAN [the National Center for Child Abuse and Neglect] provides some good data nationwide on the incidence and prevalence of child abuse. We know that their rates are running about 15.4 at last count per thousand. We know DoD-wide, we're running about eight. That's been consistent over many years. It's like many people in this room this morning have acknowledged that the folks out in the counties and the local communities will be hesitant to substantiate a case that our CRCs would substantiate in a heart beat. So, common sense would say that the military should have a higher rate per thousand, but yet we're running half. I think it is worthy of looking into that because we may find some factors that are built into our communities, into our military families that indicate

resilience to child abuse. There certainly has to be some accounting for why our rates are half of the nation's, notwithstanding the idea that there are differences in definitions. The third thing is along the idea of preventive research that Peter and others keep wanting us to get back on that research track. I think there's an outcome measure that's already DoD-wide and that's severity at case opening. I don't know what the X's would be but I know what the Y is. The Y might very well be the severity of the case opening measure, if our preventive X's, interventions, are what we need to look at. But, if they are effective, we should see over time a lowering in the severity of cases at case opening. At least in the Air Force, that's what we're seeing. So, I think there are some very fertile avenues for research, especially in the area of prevention and building healthier communities.

DR. McCARROLL: Do you want to respond, Jim?

DR. BREILING: Yes. I agree with you. I think the problem, the comparison for example, is that we don't have any control for unemployment in the general population -- all the service people are employed. There are other differences, so how do you match things up? I think what Peter mentioned is extraordinarily important. Is this because there is more propensity from the communities, or more monitoring or identification? Those could be enormously important contributions not only to the military, but also outside the gate. You have also the opportunities -- and we have Newman in New York City who pointed out the fires in neighborhoods in Chicago, the dislocations, and the crime rates that followed as people moved away from friends, neighborhoods, or social ties and networks. We know that social capital is horrendously important. Where you have deployment, for example, you have people moving to new areas. How fast can they make friends and ties? You have a tremendous laboratory here to test dynamic processes that could be tremendously important. For example, if it turns out that moving to a new area, not knowing people and not making ties increases the risk dramatically, then that is something that can be addressed. It would be extremely important. You don't need to worry about civilian versus military rates. You're dealing with a hopefully causal variable that one can then act upon.

LtCol BREWSTER: And, conversely, it might be that moving to new areas so often with our military folks forces them into being more sociable and adapting and more flexible and resilient which might contribute to the lower rates.

DR. BREILING: Correct.

DR. McCARROLL: Yes, I'd like to make a comment on the communities too. That is, I think sometimes we make assumptions about each other, that is in the civilian community and the military community. I visited an installation a couple of years ago which was bounded by two different counties in the same state. Those two counties had extremely different policies with regard to both child and spouse abuse. One of the counties would take on cases quite willingly. The other one wouldn't take on a case short of murder, practically. The issue I'd like to bring up also is that I think we assume that there is a lot of standardization of communities in the military and I don't think that's true.

Some posts have reputations as being one way or the other. I think sometimes we jump too quick to say we can standardize things. I think the issues of community standards and community cohesion take on the complexions of commanders. Posts take a long time to change. So, I think sometimes our solutions are a little bit facile in assuming that things can change so easily. I know that Marney [Dr. Thomas] has looked at CRC decision making. In spite of all the manuals and checklists you put out, you're ever going to standardize community decision making. I think sometimes we might delude ourselves a little bit about thinking we can do things that we can't.

MS. JOHNSON: The other I guess myth that we have is that all of our soldiers are on an installation. Clearly, they're not. So, more often than not, we're dealing with a population that comes to the installation to work, but live in civilian communities. That's probably the majority rather than the other way.

DR. McCARROLL: Ray?

CDR EMANUEL: Yes. I participated in CRCs for a couple of years. We hear a lot of themes here, but just to be concrete, I'm wondering if it's necessary to develop a model because I certainly haven't seen a model out there to guide a hypothesis, to guide research in the military. There's a model that people may be working on that's highly personalized when they're in the ER or the CRC. When I'm sitting on the CRC, everyone around the table has another model in terms of what they think causes child abuse and neglect and we're operating out of that. There's no consistent guiding principle. In lieu of that, we have a manual, but then I started to question the fidelity. Now, are these blanks really being filled in? Are they being filled in accurately? If you don't have that data and you don't have a model, where is your research going? I think those are really critical issues that need to be addressed. Maybe at a policy level, maybe at a center for excellence, -- but unless those are solved, should we adopt a model? Should we adopt and try several different models? How do we then ensure that there is fidelity in terms of how we collect the data? I mean, that, to me, is bedrock.

DR. McCARROLL: Peter?

DR. JENSEN: Well, you know, I think that those points are well taken as are Jim's earlier. You might gather data for policy purposes that might inform and shape policy, all of which would be very useful and be a value to research. To the extent that you wanted -- and I'm obviously selling research here today-- to the extent that you wanted to really get into this then it really means that, say, when NIH supports the research, it means we provide the funds to ensure the standardization, whether it be the common cross-site training for an intervention approach. You don't do it out of pocket. We do it. You do it with our money, basically, is what that means. So, I wouldn't limit yourself in thinking, "Oh, we have to do all this out of pocket." I mean, there are some great things you might do out of pocket and I think some very excellent operations and evaluation research can be done. When you hone down the model a bit more and say what you are really testing, the funds shouldn't dissuade you from saying you can't do it because that's what we do.

Again, I'm convinced that there are some real opportunities here. You pull together the investigative team and submit on those federal grants. It might be across a number of installations, but the money is there. This is a priority area, particularly in those three areas I mentioned: interventions, neglect and assessment-definitional issues. But that's not to take away from the etiologic pathways and identifiers and some of the other things that Bob and others have alluded to because maybe those are unique questions that can be answered in certain ways in the military that you couldn't answer in other areas. The dollars shouldn't constrain you necessarily once you've put together a top-notch protocol. It's what you're saying, Delores. It's getting the commanders to go along with it and getting your chief of police and your chief of --everybody all lined up, and your investigative team together, and the PI who's going to submit this. He or she has a world class group of consultants who have been in this area a long time and have been in on the NIH study sections and all that kind of stuff and say, "Yes, let's do this research. This is a great place to do it." It can be done.

MS. JOHNSON: Is there any interest in looking at the multi-disciplinary model that the military uses and how that works to build community cohesion and uniformity in addressing the issues? It's very clear, at least to me, based on what you're saying, that we would have to develop a model, a conceptual framework, and then a model for addressing physical abuse, neglect and sexual abuse. Even though we don't deal a lot with the sexual abuse, a lot of that is farmed out in our communities. We would have to really develop a very comprehensive research strategy that could do any number of things. One, just look at how our system works together and how the different people come together to make something happen. That would be the process because that in and of itself is a lab. Then to look at the intervention is what you're suggesting.

DR. JENSEN: Yes, but I mean there might be a very narrow question that you clearly see the link to. In fact, narrow is clearly much better than broad. But, it might be something like, Will this particular intervention implemented in this post in this way versus not implemented or staggered across several areas increase the likelihood by which mothers and fathers seek out well baby care and use certain kinds of parenting practices which we think are precursors in a child being at risk for neglect or abuse or whatever? I mean, it might be the model, but it's very specific. It's couched within your overall understanding of what you think leads to it. But, I think people are always kind of blown away when they see some of these grants because they're incredibly intensive. They usually require substantial pilot data. To get pilot data usually means somebody has got to come up with $50,000 or $100,000 to invest in really nailing down pilot data, to really show a very promising model that really seems to work. Then someone comes in for substantial federal money to really go to scale on the intervention, or the assessment or whatever it might be.

CDR EMANUEL: One other factor in the implementation phase, particularly for the active duty folks. If I come on to a base or a post as a psychiatrist and I'm incorporated into the team, my background in child abuse and neglect may not be that great.

Therefore, someone has to bring me up to speed which may take a few months. Meanwhile, other members of the team are leaving and new people are coming in. Then in two years' time or three years' time, I'm gone. During that time, there may also be a new commander. So, all the work we did with the old commander has to be redone maybe by somebody else. So, that's another layer of difficulty in terms of keeping the continuity in the research. Certainly, it would be easier with one particular site, but, when you're thinking military-wide and the realities of the turnover, it's a daunting task. Do-able, but, something that you're going to have to work into the plan.

DR. JENSEN: Well, your PIs would have to come like from USUHS or a university. It's been done, but it's very hard to have the military be, say, a PI. It has been done under unusual circumstances, but much better to get a university, a USUHS person and say, "Look, this person is our PI because they're going to be around. They're in a research setting. That's what they do." Then their collaborators become the people at the sites and they're working with a family advocacy program to get all the commanders lined up. You know, all the stars have to come into alignment. There has to be letters signed by, you know, the DESPER and all these other people saying, "You will", and then you do it.

DR. McCARROLL: Malcolm had a comment?

DR. GORDON: I think one of the most critical issues in the field of family violence is that there are significant differences in the frequency and severity of violence that people engage in. Vocal people come to attention both in child abuse and domestic violence when they engage, really, mild and moderate episodic types of violence. It seems to me that we ought to do less intense intervention, which seems to work pretty well, no matter what you do and it's almost made like an intention of consciousness-raising. Someone says to them, "You shouldn't be hitting your kids so that you hurt them." Even though they don't like it, bringing that attention seems at least to decrease engagement in physical aggression both for the spouses and for parents.

There is a group of individuals, and we've seen them both in civilian and military populations, maybe 20 percent of people, who engage in repetitive and severe violence. They don't seem to stop. It doesn't seem like intervention is very effective with them. We often say to these people, probably the best intervention is to just keep them away from them. These are people that -- for instance, spouse abusers -- who will repetitively injure their spouse. If there's a divorce, the women leave, they'll enter another abusive relationship. We really don't know so much about these people, particularly prospectively. I mean, they are identified after the fact and we try to get information about their history and so forth, but they're not really good people to include in research. I think the military has kind of a unique opportunity. There are some ongoing longitudinal studies looking at antisocial individuals that get at low base rate behavior. You have to identify people that have engaged in domestic violence and then that small group of those who are more severely violent is hard to locate prospectively. The military has an option because they get a lot of data when people enter the military service, like in the Navy study. You might have a chance to look at prospective measures

of the characteristics of these individuals when they enter the military service. I have not seen any other place that has kind of ability to gather such information about individuals.

DR. MILNER: We're changing the purpose a little bit. We're talking about what these people are like when they enter, what your recruit profile looks like. I think it ties into something Delores said earlier about whether we are taking in or pulling in men who are more aggressive to begin with and then they just continue it. We're involved in a Navy project --we're the primary data collectors. We just completed the first round of three hours of testing, 20 different surveys, asking about childhood physical abuse, childhood sexual abuse, intimate partner violence, head trauma, trauma measures, asking other kinds of trauma -- a collage of scales representing different theoretical models because we had five consultants with different theoretical perspectives. We've collected data on 11,150 Navy recruits over a 12 month period. We just finished on June 17th. We have data on about 95 percent of all the women recruits entering and an equal number of males. This project is longitudinal. We are retesting at six months. We're also tracking them for attrition, job performance, mental health utilization, physical problems, and so forth. What I have in my hand here is a table of some results of a pilot study that was done in '94 in Orlando. Again, it's just pilot and it is public. The results of this ongoing project have not been cleared yet, but it's holding together. We're going to follow up at six months and 12 months -- about 45 percent return. It is totally voluntary and the people are moving around – so you'll be hearing about that in a couple of years. I think we didn't start at the right place. I think the place to start is something that was alluded to earlier. That is, what are we getting into the service? What are their characteristics? I'm being a little facetious there. I think all these discussions are important. I believe in community issues and community factors, et cetera.

Okay, what is this? This is a table of 1,083 female recruits. This study was done in Orlando and there were three training facilities opened: San Diego, Great Lakes, and Orlando. As you know now, Orlando has been closed. San Diego, the training center, is going to close and everybody is trained at Great Lakes. We just happened to be nearby which is one of the reasons we've been involved. It makes a lot of sense, right? Middle of the country and instead of using the coasts, we're training Navy folks. There is a lake nearby. A sample of 1,083 were given a shortened version of the survey we're now using. We used the CTS [Conflict Tactics Scale] to ask about physical abuse. This is the severe and very severe sub-scales on the CTS. It was modified in its instructions. It asks about your parent and how you were treated. Now the problem I have with this -- to be critical of our own research -- is that it doesn't ask about injury. It asks about the parents' behavior. These are females and there's a reason why, because this is in a report that I happen to have with me. A total of 17.7% reported on the CTS the experience of violence or severe violence from their parent before age 14. This is all before age 14 from a parent. Then, 16.9% sexual abuse and 22.2% both. These are exclusive categories. If you add up the three numbers to your right, you'll see that about 57% come in with child abuse history: physical, sexual or both. I think this is important because if you look at, for example, something like whether or not they were raped between the ages of 14 and 18 by a peer or an adult outside the family, what you'll notice is that if they

experienced physical abuse, 22% of the time, compared to no abuse, rape rate of 20%. But, look what happens when you have sexual assault prior to age 14. Just about half of these women between the age of 14 and 18 were forcibly raped and it goes to almost 60% if they experienced both child and physical abuse and sexual abuse prior to age 14.

We haven't given much time to the discussion to victims. I didn't in my presentation. I looked at offenders. But this means that almost three out of five female Navy recruits coming in come in from very violent backgrounds, from family backgrounds that are violent and peer relations and other community experiences which involve rape. Then we find that in the Navy -- what is it, after two months, 18% have attrited and it's in the 20s after four months. The old line was, "Well, women just can't take it. They're weak. They're not strong." A lot of them have PTSD-type symptoms as you know. This is when they are just coming in, so it is pre-military. What's interesting is one out of nine males admit in the prior four years, they forcibly raped a woman. I would imagine that this rate is low. I mean, they know they're being evaluated, that people are going to be seeing this. One out of nine admit they've assaulted. This is very soft now. My view is, we're bringing these women into a male environment. I don't know how the Army is, but this is a recruit training center. If your cap isn't straight and square in the back, they'll put you against the wall and scream in your face loud and hard, maybe two or three minutes, cursing and everything. Think of a woman who's had this kind of history -- the majority have had this kind of history -- being brought in. They're away from home, no support system. It's a male environment, male values. They are sleep deprived, fatigued, and they're are co-mingled. They may be next to one of the prior offenders in terms of personality style and the kind of comments he makes, et cetera. Then the women drop out because, "They're weak and can't take it." They decompensate for good reason because of the stress and because they're face-to-face with offenders and are without a support system in a male environment, et cetera. We're trying to demonstrate that with data, which is just my opinion.

The other reason data like this are important -- what's my point? We need to know who's coming in. Who are you dealing with here? If a woman has been sexually abused as a child -- let's stay with these data -- the odds ratio is 4.7. They're 4.7 times more likely to have suffered rape from age 14 to 18. That's similar to the civilian data. What we also know is, sadly, once the woman has been raped, she's more likely -- according to civilian data -- to be raped a second time. It's hard to predict first-time rape, but we do here. But once you have a childhood history of rape, you're more likely to suffer rape again and you're more likely to suffer from sexual harassment. These things all intertwine. Again, it's very complex and I don't have the answers. But, I think you need to know who's coming in. I think you need to have a good sense of both the male's history of criminal activity, alcohol and drug use, support or lack of support system, childhood physical and sexual abuse.

We have a study that we're finishing right now as I speak, which will be the first study to look at males who raped and what's their background is like. You think that it would be in the literature. We did a complete search. It's not there. We studied women

who have been victims of rape, but we don't study the rapist and go back and look at whether they've had childhood physical abuse, sexual abuse or both. You get the sense of how the experience of child and physical abuse and sexual abuse causes victim effects that the Army may be very concerned about in terms of pre-victimization. I'm not blaming the woman. We did present at APA – I presented a step-wise, hierarchial design where we did try to look at some of the other predictors of a woman being re-victimized. This is retrospective and it's during that four year period. We're heading this way in terms of longitudinal studies. Two things we looked at, and then I'll stop. One was number of sex partners. Because we know, generally, that if a woman has been sexually abused as a child, she tends to later have more sexual partners, even though some have none according to John Briere. As a group, they have more sexual partners. If you have more sexual partners, since about one male in five is sexually aggressive, you increase your risk of being raped. We also looked at alcohol use. Both of those entered the regression analysis. That is, for those that had the history and had more partners, that further increased the R-squared, and alcohol use entered minimally, but it entered. We looked at an interaction, too – had more partners and you use alcohol a lot. We thought for sure that was going to show up, but it didn't. But, there may be some statistical reasons why that didn't. Any questions? Comments? Criticisms? So, what's the point? The point is, I think you need to look at both your males that you're drawing into the Army and what their background characteristics, but also the women. I don't know whether you're like the Navy, but is your attrition rate much higher for women --dropouts and do you know why? We're going to have some guesstimates here as to why. It's a shame to have the woman come in and be victimized again and again because of the early assault

DR. URSANO: I agree with the danger of taking a single variable. Let me remind everybody that one of the indicators of having been raped and making it in the service is that one has a high level of coping skills just to be able to survive what has been a very difficult background. One then may have demonstrated exactly the skills that will allow one to survive in many of the highest stress environments in which we put our people. There are multiple studies that look at what is the relationship between deviance and success? Those are not opposites. They are at times the same thing. Beginning with studies of prisoners of war from the Korean War in which you look at how similar are those people who collaborated during Korea versus those that were high resistance during Korea, people that we gave medals to. In fact, they were exactly the same on all the levels of deviance that we usually measure. Where they differed is who they bonded to. So, one has to be very careful as to whether or not when selecting out one's ace fighter pilot at the same time that one selects out someone who may be vulnerable because many of the traumas of a lifetime also create skills for success. So, it's a multi-variable model to come up with the people that may be at the biggest risk.

DR. McCARROLL: We're approaching lunch time. Are there any final comments from the morning?

Spouse Abuse Research

James Breiling, Ph.D.

Moderator: LTC Ann E. Norwood, M.D.

DR. McCARROLL: Thank you for your spirited comments and discussion this morning. I think we ended in a place where we were making a smooth transition to the arena that we want to cover this afternoon which is spouse abuse. I want to introduce my colleague, Ann Norwood, the Associate Chair of the Department of Psychiatry at USUHS.

LTC NORWOOD: I have the very pleasant task of introducing our next two speakers. First, we'll be hearing from Doctor Jim Breiling. You've had the advantage of hearing some of his contributions already this morning. He has a nice title that's really long and ends with, I believe, epidemiology at NIMH.

He has a very long and distinguished career, as you noted. He really -- and I hesitate to use this term -- is the father of sexual offender studies. He's done a lot of work in that field and really, is a pioneer in getting the whole area recognized and studied. It's gone from the mid-'70s when there were just two dozen programs throughout the whole US to now over 1,000 programs. So, it really has been an area where his efforts have paid off.

He has been recognized numerous times. Just to mention a couple, one is by the Association for the Treatment of Sexual Abusers. He received the 1996 Significant Achievement Award. He has also been very involved in the study of chronic and serious antisocial and delinquent behavior in youth. He has a large interest in research in domestic violence and is an expert, in general, on dilemmas associated with anti-social and violent behavior.

So, I will now turn it over to him and give him the microphone.

DR. BREILING: The real concern these days is to get knowledge out and get it utilized, particularly in the health arena. So, one of the things I want to do today is to share with you the results of probably what was the first consensus conference. As some of you may know, we're doing a lot of consensus conferences at NIH, pulling together experts on the state-of-the-art recommendations. We had one just the other day on acupuncture.

This conference was far-ranging. It involved the major physicians, medical personnel, and covered the whole spectrum of medicine with major implications for reducing mortality, morbidity, increasing well being, and significantly decreasing medical care costs. These are all things you can readily implement to improve your own life, as well as those you know.

I just can't resist opening with this to share knowledge with you, about clinical agreement. I should tell you this comes from 1902 (Figure 1). You know, if your ear is bothering you, just three leeches will take care of the earache (Figure 2). Now, remember, there was clinical consensus about all of this. If you're seasick, thinking of a voyage, breathe in when the ship dips and breathe out when it rises (Figure 3). Clinical consensus was that this would make a difference. Cure for the common cold, no problem

(Figure 4). Starve it into submission by drinking no liquids for two days. Clinical consensus! Bothered by tetanus (Figure 5)? Pour cold water on the head from a considerable height. Now, having done that, if you're worried about that, you may be worried about losing hair (Figure 6). Of course, men are vain, too, and you want to apply a little water and rub it. It's better than hair pieces, surgery and other things. Of course, if you're having problems urinating, a marshmallow enema will take care of it (Figure 7).

Remember "marshmallow enema" anytime anybody in the domestic violence area is telling you they have what works and so forth and they don't have data. Just think, "marshmallow enema."

Diabetes (Figure 8), caused by excessive sexual intercourse, intemperate living, copious evacuation of the bowels, may be treated by having the patient wear flannel clothing, eating no vegetables, puking regularly and using soap bar suppositories. Much better than insulin? No, we don't think so. Rheumatism, cataracts, convulsions, and so forth all respond well to generous and sustained doses of laxatives (Figure 9). Agree? Cancer (Figure 10)? No problem. Just apply a combination of figs boiled in milk. Clinical consensus! Women's depression (Figure 11)? A little peach leaves and beer hops will take care of women's depression.

Hysteria (Figure 12)? Bind the woman's hands to prevent her from injuring herself. Heat a piece of steel in boiling water for two minutes and wrap it in silk and pass it down her spine. Of course, apply an enema. Very important, obviously, to hold the woman in a tranquil state. You know, masturbation (Figure 13). Highly corruptive. Violence (Figure 14)? We can eliminate violence because it is caused by "violent mental emotions" following or immediately preceding conception. So, here's a sure-fire prevention.

Now, why have I gone through all this nonsense here? It is that this is really where we are in the spouse abuse practice. It's marshmallow enemas, and heated steel wrapped in silk passed down. And as we'll see, I think we already know enough that most of these programs are ineffective, inappropriate, and a waste of money. They are equivalent to this and they ought to be ended as frauds. If they were drugs, we would take them off the market for lack of support. That's really where we are in the spouse abuse area with the bulk of what's happening.

Now, is this so bad? Well, let me tell you one of Breiling's great discoveries (Figure 15) was that no one has ever been bitten by a vampire the night after they've eaten garlic. That's a scientific fact. It also means you'll see people making claims analogous to what claims they make in the spouse abuse area about how effective the treatment is. The corollary of this is, you shouldn't believe anything unless it's founded upon convincing data from a rigorous experimental design (Figure 16) which is obviously lacking in the case of Breiling's great discovery.

So, the issue here in our field that we have is really kind of a crisis these days. It's whether we're going to operate on clinical beliefs -- the marshmallow enemas, the leeches in the ear, and the soap suppositories or whether we're going to operate on scientific knowledge. Actually, it's very exciting that your interest in this area is in going the other way, but, I would suggest, there are already some very compelling data in directions of how to go to make a difference. We see this in the sexual harassment area where you can have great things on paper, but don't work in the field. That's where we are in this area.

I've been involved with deviance for about 30 years. In 1970, when I really got substantially involved, it was in the delinquency area. We really didn't know very much, but since then, by 1985, it became very clear how to make a major difference and intervene. There's lots of little loose ends to fill out, but as I'll indicate to you, we know what to focus on. We know how to do it. We know how to make an enormous difference in serious and chronic delinquency. Of course, virtually everything that's being done is ineffective. That's because it's not founded upon this. This spouse abuse area is like delinquency was in 1985. The major parameters are becoming clear, where to focus and where to go, and most of what's being done is irrelevant.

Now, one of the corollaries I'll mention. One of the issues here is that all data are not of equal value (see Figure 17). Because there are data, doesn't mean it's of equal value. There's a lot of stuff that's just absolute garbage and is not worth pursuing. There're other things that are more important. I'm just going to focus upon some major heavyweight stuff that pulls it together.

The other thing is that tough problems will often yield to a sustained effort (see Figure 18). What we tend to have in research is a lot of hopping around methodologies that don't quite work out and people drop out. If it's a major problem, you stay with it and build upon that. When that's happened in the areas that I've been acquainted with, effective answers have emerged. Now, very often, the initial efforts are failures. But, if it were easy, it wouldn't be such a persistent and difficult problem. Actually, in this field, compared to almost every other area that I know that NIH is involved with, the progress has been dramatically faster with far less money. I think it's because of the caliber of people like Dan O'Leary and Joel Milner that we've gotten into the area.

Now, what do we know in the spouse abuse area (see Figure 19)? Well, one of the things, as in crime and delinquency, a small proportion account for the bulk of whatever you're concerned about (see Figure 20). That's true in delinquency, that's true in crime, and, it's true in spouse abuse. That's true in your own data. Remember the slide last night? A lot of minor physical abuse, but the serious abuse was down there way at the small part. That's true in the domestic and spouse abuse area. A small proportion accounts for it. And by the way, very few people do serious spouse abuse violence. Almost all of them engaged in serious violent behavior before 21 because almost no violence is initiated after age 21 that hasn't occurred beforehand.

So, there's a couple of corollaries here. There's a small proportion that account for the bulk of it. This is true in the San Diego set, Navy study as well. Now the Navy study, for those who don't know, was really state-of-the-art exactly the way you want to do it. Random assignment of people referred for misdemeanor spouse abuse. One-quarter -- we're talking almost 1,000 people here, sailors. One-quarter just got a three hour safety planning session for the wife. Another quarter got couples' treatment. Another quarter that was overseen by Dan Saunders, manuals, high fidelity, all the things you'd like, state-of-the-art. Another quarter got batterers' group treatment. Bob Geffner oversaw the couples' group and Saunders did the batterers' group. One quarter got Breiling's idea of rigorous monitoring. Rigorous monitoring was to call a woman every month and ask her what her husband had been doing and report that to command.

Now, what were the major results? On treatment, whoosh. None of the interventions had made any difference in outcome. You're just as well to do the three hour safety session. So, let's forget about these batterer group treatments. Let's forget about the couples' group treatment, the one-size-fits-all. They don't work.

Now, consistent with some other things, there are things that do work. Consistent with the other data, over half of these people did not recidivate. Most of the recidivation was minor. There was a small proportion of serious, chronic offenders who really carry pride in their work. And they are night and day different from the rest of the folks. Every single measure you can imagine: depression, self esteem, and they are sky high on psychopathy. Cowardice, manipulative -- these are people that if you look at those characteristics, you would say, "It doesn't match with any of these treatments."

But, we have a lot of people that don't recidivate like most delinquents don't recidivate. We have learned in the delinquency area, not to do things. You could only make it worse. It's like treating the common cold. It's going to run its own course and drop out. Now, for the other substantial part that do recidivate, typically very minor, let's talk about that.

Overwhelmingly, and Dan O'Leary has compelling data on this, this is incidental to real marital distress. The focus here needs to be on the marital distress. The couples are not bothered by these occasional slaps and pushes. Let's also consider how most cases of spouse abuse enter the justice system. It's not because someone was screaming and yelling or that they're being choked or shots were fired. It's because there's noise: shouts, bangs and the neighbors are bothered. Most of this then arises out of marital distress.

So, we have a substantial part that we could divert out that are at low risk. Then we have another substantial part for which marital distress is a major factor. We have another core group that are very psychopathologic. None of these existing treatments match up with the existing groups. They just don't fit.

In terms of the types, Amy Holtzworth-Monroe has done a very compelling, superb review of analyses of types of spouse batterers. Of those chronic batterers who are doing most of the serious stuff, about half of them are anti-social personalities (see Figure 21). These are long-term, high rate deviant folks. Now, there are things to do there, but they are not the things that are typically done. They have many other problems which are not typically addressed in the programs or by the assessments. If this were a medical setting, we would have suits for medical malpractice for inadequate diagnosis and disposition. To imagine that putting this person in the typical type of treatment without assessment and dealing with the depression and the other problems and their anti-social behavior would just be absurd.

Another substantial portion have a borderline personality disorder (see Figure 22). They also have a background of abuse difficulties, alcohol, substance abuse problems, and a greater fear of abandonment. You get the over-control and so forth and they often have mood disorders. Depression is a frequent thing. Now, the question is, do these treatments match up? If someone is insecure enough to worry about abandonment, would you confront them seriously about their anti-social behavior? No. In fact, Dan Saunders now has data that, if you differentiate these groups, give the anti-social fellows the more cognitive behavioral treatment focused on their anti-social behavior, and give the borderlines more supportive treatment, you get much better results. One package, one size does not fit all.

Now, because most of the serious offending -- and I would suggest that's where our focus really needs to be that these serious, chronic guys are really something. These are the guys who are terrorizing their wives. They're doing the assaults. Because those characteristics are so strong, it suggests a couple of approaches. One is prevented by excluding (see Figure 23). Identify these folks at recruitment, during initial treatment, to either preclude from the service or to separate them early. You already have a number of such things.

Now, there is a problem with this. We don't have all the variables identified completely, but it's do-able. Number two, you're never going to have perfect prediction. I'm going to suggest a way to handle that. The other thing is, preventive interventions once they're in, which could be prior to marriage, after marriage, or after spousal assault. I want to suggest that because their characteristics are so strong and pervasive and powerful, that the same type of intervention would not be used in each case. The normal kind of marriage enrichment is not going to be particularly helpful with this group with their needs and problems.

Now, if we prevent by excluding (see Figure 24), the issue to be grappled with is what degree of accuracy is acceptable? It's not going to be perfect. What extent of differential exclusion would be acceptable because we're going to get differential exclusion by groups? I indicated some of the reasons when we were talking about black/white differences on anti-social behavior, career length and so forth, and who's in different settings. We'll come back to that.

The other thing that you have to know is what are the major predictor variables and whether they can be assessed in a cost efficient and effective manner. There's some handle on that. Then how does one deal with the high rate of false positives (see Figure 25). Now if you're screening generally in the population, just to show you the problem here. If we have 80 percent accuracy, which would be very, very good in a five percent base rate, and we're making a prediction here from 100 people, we're going to be right-true positives before the five folks that are going to be meeting this criteria, let's say anti-social personality are becoming battered. We're also going to have 15 false positives. So, we're going to be excluding a large number of people falsely, although we're not going to do bad down here.

Now, is there a way to overcome that? The answer is, there may well be. It's called multiple-gating (see Figure 26). You have a series of assessments. Now, to do this, you have to have multiple predictors that correlate minimally with each other and all correlate well with whichever you want to predict, serious spouse abuse. You begin with the easiest and the less expensive. Assess further only those identified at most risk.

Now, for example, it works out you want to predict what kids are going to become serious or chronic delinquents. We have a number of characteristics. First, you go to the classroom. We know that teacher ratings are pretty good predictors. You ask the teachers to rate the kids' conduct problems. You then predict from that and you only consider further those who are very high in conduct problems in the classroom. You then do a quick phone assessment with the parents. We know that parental variables are very important. Again, only pursue further those who score high on parental problems and do a third assessment. The result is, you change the base rate dramatically that you're working with when you make your final prediction. So, there is potentially a way to get around this, but it's still not going to be perfect. It is one avenue.

Now, one question here that came up earlier is that resources are limited (see Figure 27), both for research and for programs. This is why it's so important that we have effective diversion and focuses. If we're going to make a difference here with the chronic and serious folks, we've got to save money by diverting out those who are at minimal risk. But, we need a comprehensive differential assessment (see Figure 28. Who is at risk? What are the risk variables? What are their other treatment needs? That typically, I would suggest to you, does not occur very often. The problem is that we're operating on a one-size-fits-all mode, and, in fact, it doesn't (see Figure 29).

Now, again, the key note is that a majority do not recidivate (see Figure 30) and a substantial part of those who do, don't show up with the police. They do show up in self reports, but it's typically minor. We have to consider how much time do you want to spend on those when they're not doing the serious stuff?

DR. HAMPTON: Point of information.

DR. BREILING: Yes?

DR. HAMPTON: Recidivate. You mean serious injury?

DR. BREILING: No. The bulk of the folks that come in, as in San Diego, do not do a serious re-offense. I'm not talking choking, hitting, using a gun, knife injuries. I'm talking about a push that happens every four months, or a slap.

Now, another issue that's not been confronted in this field is that treatment can be harmful as well as a waste of money (see Figure 31). One of the ways it's harmful is in these group treatments, fostering association with other deviant folks (see Figure 32). There is no support whatsoever for positive peer culture or other methods of working with groups to obtain positive change. None! If you can find any, I'd be delighted because I can't find any. I've asked a number of other people and it doesn't exist. We have strong longitudinal experimental data with adults and adolescents that associating with delinquent peers is a powerful factor to foster deviance.

For example, in sex offender groups, people will say, "Oh, I had these child molesters with us. We had a great session." You say, "What happened afterwards?" "Well, yes, I noticed they were out in the parking lot for an hour-and-a-half afterwards." What do you think they were talking about out there? Hey, they're sharing their kiddie pictures and foreign porn and where to pick up stuff.

And delinquents do this. We know that within the most positive peer cultures that we can obtain in group homes, when the kids associate with each other that they foster enormous amounts of concurrent delinquency. This is extraordinarily strong. Longitudinally, only one out of 44 delinquents goes on to serious and chronic delinquency without picking up other delinquent friends. If they don't pick up delinquent friends, the odds are progressing are very low (see Figure 33).

Harry Thornberry in a longitudinal study in Rochester, just to name you some examples, found that when the kids had delinquent peers, they had delinquency rates that were very comparable with the serious offenders. During periods when they didn't have delinquent periods, they were relatively normal Scott Henggeler in his homemaking intervention and now therapeutic foster care are showing that those are the keystones. Therapeutic foster care, where we eliminate association with deviant peers, blows the group homes away. Just blows them away. And I can rattle off all sorts of data here.

So what about group treatments in adults? When you analyze predictors of recidivism, what emerges is that one of the strongest predictors: association with delinquent adult offenders and deviants in support for anti-social attitudes. Where do you get that? There's a whole array of stuff with adults. That's a major focus. So, the usual group treatment of bringing problem people together could be properly classified, at the

very least, as experimental (see Figure 34). As experimental treatment, it should be subject to consent forms.

But I want to suggest, by the way, is the way to proceed. What people do is they start out with the modality and say we work with groups. The way to go is to identify the risk factors (see Figure 35). What are the major risk factors that you can change? How can you change them effectively? Then you decide on the format of what's the most efficient way to go? You turn this upside down by saying, "Hey, I've been trying bloodletting. So, when you come in, I'm going to routinely bleed blood and then I'll go on and examine you." That's crazy, but that's how we're stuck with this group model. So, I think the group model should have an informed consent (see Figure 36). They should identify the risk and it should state plainly that there's no demonstrated benefits. That would be a fair and informed consent.

As we mentioned, marital distress is inherently a major problem (see Figure 37). Few have serious conflict that do not have marital distress, but it's rarely addressed in these programs. What we do have with the chronic offenders given their anti-social personality and the borderline personalities is a criminal psychiatric problem (see Figure 38). This is not an educational problem. The criminological literature has been clear. For example, one of the premises is, These guys don't know the harm they're doing. I've got to tell you, 25 years ago it was established with prisoners, judges, college students, they all rated the seriousness of offenses the same. There's no lack of knowledge here about what's harmful. To assume that just a quick teaching of some learning skills with this group -- there's a lot of problems there we can talk about -- is going to be effective in general, it's like learning ballroom dancing from a book, or learning how to play golf well from a book or a classroom. That's not the way to do it. Those are not necessarily the key variables of whatever you've addressed.

What we have to do then is to identify. If we have a malignancy area, modifiable risk factors, we have to focus on that (see Figure 39). What's the prescription to deal with that? To get an effective impact or dosage. How to deliver that effectively? How to have that dosage take hold and maintain it? Most of these folks are not going to be cured and they're going to continue at risk. We're talking management. Medications are going to be an important component to deal with the impulsivity (see Figure 40) -- and there are compelling data in terms of hyperactivity and attention deficit disorder, that you need medication to deal with that and the high rate of depression. So, if there's not an active psychiatric medical involvement here, there's a boat being missed.

Psychosocial therapy for the anti-social personality (see Figure 41). We've got to deal with the attitudes. We've got to deal with the peer associations. We also have to -- because most of these fellows did not do well in school, are way behind, another educational experience is not the way to go. We need concrete models that recognize their learning problems and we need ways to generate motivation to adhere to the treatment regimens. Given the treatment, it is not going to be curative. We're going to have to also foster cooperation with other external controls. That having been said,

there's relevance for other systems including the justice system involved in detection (see Figure 42). We shouldn't exclude Stop It Now self-referrals (see Figure 43). The justice system has requirements here in terms of participation, and, most effectively, the monitoring and supervision and the accountability standards.

Now, one of the things the treatment people complain about is that the justice system -- these guys need to be enforced to be in treatment, and that's a problem. I've got to tell you, the other half of that is that we have to look at the programs and say, "Are they treating these people with decency, with the respect?" C. Everett Koop is the model here in regard to HIV/AIDS. He does not agree with the homosexual behavior for his religious belief, but by that same religious belief and his training as a physician, he felt that there were people to minister and serve even though he didn't agree with the behavior. And he approached, as you know, with his newsletters and other means with dignity and respect and concern. That's often lacking. Look at these programs. If you saw frequently how the people participating are treated, no wonder they wouldn't want to come back.

One of the things I mentioned about rigorous monitoring had a real promise in San Diego (see Figure 44). It didn't make a difference in recidivism, but the rigorous monitoring -- when the wives were called each month and asked what their husband's behavior was and that was reported to command during the time that was in effect, there was a tremendous boost on the measures of women's personal characteristics: self-esteem, less depression, and so forth. So, there's really something going on here that's very important, particularly for the women who are most terrorized.

Last, but not least, talking about the women, we need to be concerned about women offenders (see Figure 45). Now, there's no doubt that the women are the serious victims of this, but it's not entirely a one-way street. Every survey that I've seen shows that women have a higher prevalence of partner aggression than males. As with men, Terri Moffitt finds out the strongest predictor with females as with men of partner aggression is prior aggression during adolescence. There's considerable assertive mating. That is, that highly aggressive men and highly aggressive females tend to partner up. That has some implications that we need to address.

Last, but not least, I want to suggest that there are real issues here in dissemination and utilization and getting things into practice that are not solved by a clinician, by research articles and by papers. You have to be out in the field. You have to carefully monitor it. And in terms of the implications here, there's tremendous needs, given this area, for a clinical research network. That there's a lot that can be done in following up with assessments, if your assessments are good. You can do this given your capability for following up, and also for open trials where programs work to measure the impact, upon mediating variables. If you can't get the dosage taken, why is there any treatment effect? That's something that can be worked on right now.

So, I've kind of whipped on fast, but I hope I stayed within the time. Thank you for your patience.

DR. BREILING: And remember the "marshmallow enema!"

LTC NORWOOD: Thank you for that wonderful and entertaining presentation

The Cottage Physician

written by a consortium of
"the best physicians and surgeons
of modern practice"

Cautioning against quackery, it promises
"The Very Best and Most Approved Remedies and
Methods of Treatment Known to Advanced Practitioners"

Figure 1.

Earache –

best treated by the application of three leeches to the affected area

Figure 2.

Seasickness –

breathe in when the ship dips and out when it rises

Figure 3.

Cure for the Common Cold

Starve it into submission
by drinking no liquids for two days

Figure 4.

Tetanus

pour cold water on the head
from a considerable height

Figure 5.

Prevent Baldness

apply pomade of lard and rum

Figure 6.

Restoring easy urination –

difficulty in urinating requires a marshmallow enema

Figure 7.

Diabetes ...

caused by

excessive sexual intercourse
generally intemperate living
copious evacuation of the bowels

treated by

wearing flannel clothing
eating no vegetables
puking frequently
taking suppositories carved from soap bars

Figure 8.

Rheumatism

Cataracts

Eczema

Convulsions

Sciatica

all respond well to
generous and sustained
doses of laxatives

Figure 9.

Cancer – who gets it, and its cure –

A serious matter, not to be trifled with, but, fortunately limited mostly to individuals of 'scrofulous constitutions."

Many tumors can be eliminated by the application of 'a poultice of figs boiled in milk.'

Figure 10.

Treating Women's Depression –

'When a woman feels that she is growing more discontented with life, that it is a burden, and she is very nervous and irritable, she should consult her physician, and nine times out of ten the whole trouble will be with the womb.' Often her womb will have 'fallen, ' an unfortunate condition that appears to have reached epidemic proportions in turn-of-the-century America. It can be nicely rectified through a douche made from peach leaves and beer hops.

Figure 11.

Hysteria –

Women are particularly susceptible, and the cause is again to the womb.

For treatment: Bind the woman's hand to prevent her from injuring herself. A piece of steel, heated in boiling water for two minutes and wrapped in silk, should be passed down her spine. And last, an enema should be administered consisting of turpentine and stinkweed. During this procedure, it is essential that the women be kept 'tranquil.'

Figure 12.

Highly Corrupting Secret Practices –

By far, the most fevered part of this journal, where the author-doctors have permitted themselves the greatest adjectival excess, is the seemingly endless section devoted to preventing certain unnamed 'secret practices' of the nation's youth.

Shockingly, even girls are susceptible to this solitary temptation, and mothers are warned that if it is not curtailed it will lead to 'the grave, the mad-house, or worse yet, the brothel.

... the cerebrum is robbed, memory is impaired, the digestive system is weakened.'

Treatment for this affliction includes strict moral instructions and the scrupulous avoidance of all stimulants, perfidious agents such as 'wine, coffee, liquors, novels, love pictures, balls and theaters.'

For a parent to know of this problem and fail to apply remedial measures, the doctors opine, 'would be to be guilty of a crime most heinous, and scarcely second to that of murder.'

Figure 13.

The inter-generational transmission of violence –

> 'If within an hour or two of any violent mental emotion the impregnating act follows, the offspring has that predominating trait throughout life.'

Figure 14.

Breiling's Discovery

No one has ever been bitten by a vampire in the night after eating garlic.

A rigorous experimental design is a necessary condition for addressing efficacy.

Figure 15.

Clinical Beliefs

or

Scientific Knowledge

Defensible, empirical data re input to outcomes.

Performance-based rather than activities to be developed and provided.

Figure 16.

All Data are NOT of Equal Value

Figure 17

Tough Problems Will (Often) Yield

to Sustained, Cumulative Study

Figure 18.

What Do We KNOW?

Figure 19.

A Small Proportion

Account for Most of the Problem

Figure 20.

Antisocial Personality Disorder (ASP)

"The essential feature of ASP is a pervasive pattern of disregard for, and violation of, the rights of others that begins in childhood or early adolescence and continues into adulthood.

"Individuals with this disorder may also experience dysphoria, including complaints of tension, inability to tolerte bordom, and depressed mood. They may have associated Anxiety Disorders, Depressive Disorders, Substance-Related Disorders, Somatization Disorder, Pathological Gambling, and other disorders of impulse control.

"ASP appears to be associated with low SES and urban settings."

Figure 21.

Borderline Personality Disorder (BPD)

"The essential feature of BPD is a pervasive pattern of instability of interpersonal relationships, self-image, and affects, and marked impulsivity that begins by early adulthood and is present in a variety of contexts.

"Individuals with BPD make frantic efforts to avoid real or imagined abandonment.

"BPD often co-occurs with Mood Disorders."

Figure 22.

Prevention

Excluding the "High Risk"

-- At recruitment

-- During initial training

Preventive Interventions

-- Prior to marriage

-- After marriage

-- After spousal assault (to prevent recidivism)

Figure 23.

Preventing by Excluding:

What degree of accuracy is acceptable?

What extent of differential rates of exclusion would be acceptable?

What are the major predictor variables, and can they be assessed in a cost-efficient and effective manner?

Figure 24.

80% accuracy
N=100
with a 5% base rate

	True	False
Positives	**4**	**15**
Negatives	**80**	**1**

Figure 25.

Multiple Gating

A series of assessments

Requires multiple predictors that correlate minimally with each other.

Begin with easiest and least expensive

Assess further only those identified as most at risk.

Figure 26.

Resources

Are

Limited

Figure 27.

Comprehensive,

Differential

Assessment

Extent of Risk

Major Risk Variables

Other Treatment Needs

Figure 28.

One Size

Does NOT

Fit All

Figure 29.

A Majority Do NOT

Recidivate

Figure 30.

Treatment Can Be

Harmful

and

A Waste of Money

Figure 31.

Associating with Antisocial Peers

(even when via a treatment context)

Generally Supports

Antisocial Behavior

Figure 32.

Youth with behavior problems are unlikely to escalate to more serious and high rate anti-social behaviors – and to violence – unless they associate with peers who are highly deviant. Of those youth who do progress to more serious and chronic anti-social behaviors, less than 3% do so in the absence of deviant peer associations (Elliot). A recent prospective longitudinal study underlines the key role of deviant peers. One group of youth engaged in serious and high-rate anti-social behavior all three years of the study. Another (much larger) group of youth engaged in only a little, minor anti-social behavior in all three years, and had virtually no highly anti-social peer friends at any time. A third group engaged in serious and high-rate anti-social behavior during one or two years, and during that time had deviant peers; at the other times, their behavior was as good as the second group (the angels) and they had virtually no anti-social peer friends then (Thornberry). Some experimental support is offered for the pivotal role of deviant peers in supporting serious and high-rate anti-social behavior; changing peer association to pro-social youth was a major focus for this successful intervention (Henggeler).

Figure 33.

Usual Group Treatment

Could Be Appropriately Classified

As Experimental

Figure 34.

Risk Factor ID

and Intervention Method

BEFORE

Format

Figure 35.

Informed Consents

Risks – increased recidivism

Benefits – none

Figure 36.

Marital Distress

Is Inherently

A (if not THE) Major Problem

Figure 37.

Spouse Assault

As a Criminal Psychiatric

Problem

Figure 38.

Modifiable Risk Factors

Rx and Dosage

Deliver

Dosage Take

Duration of Dosage Take

Figure 39.

Drugs

For impulsivity

For depression

Figure 40.

Psychosocial Therapy

for Anti-socials

Risk factors for anti-social behavior – attitudes, associations

Concrete models (recognize learning problems)

Motivate to adhere to other treatment regimens and to cooperate with external controls

Figure 41.

Justice System

Detection (should not exclude self-referral)

Requirements

Monitoring, Supervision, Accountability

Figure 42.

STOP IT NOW!

Information and

Self- and Other-Referrals

Figure 43.

Rigorous Monitoring

And

Women's Mental Health

Figure 44.

The Woman

Higher prevalence than males

As with men, prior aggressive behavior is the strongest predictor of partner aggression

Figure 45.

Spouse Abuse Treatment Research

K. Daniel O'Leary, Ph.D.

Moderator: LTC Ann E. Norwood, M.D.

LTC NORWOOD: Our next speaker is Doctor Dan O'Leary who is a Distinguished Professor of Psychology and the past Chairman of the Psychology Department at the State University of New York at Stony Brook. For those of you who have done some of the background readings, you'll see his name appears a lot. It was not with much surprise that I read that he was among the top 100 cited psychologists in the English speaking world according to the American Psychologist. He's a very thoughtful individual who has given a lot of attention to this.

He began his research career focusing on token reinforcement, self-control, hyperactivity, and observational methodology. Then he has moved on, more recently, to the areas of marital therapy, the relationship between marital and child problems, and spouse abuse. He has lots and lots of well-earned awards.

DR. O'LEARY: Well, I guess I first have to say that I've been involved in treatment research for some time. Since Jim Breiling has already warned you that we don't really know much, I'm one of those people who has been aiding and abetting that lack of knowledge. But I've also tried to look at causes and correlates of the problem. Actually, we know a lot more about the correlates and the causes than we do about the treatment. I'm going to talk about why I think we need a lot more effort focused on the treatment side. I'm also going to talk about why I think the Army is an excellent arena in which to look at that.

I decided, as I was preparing my talk and as I heard things yesterday, that instead of launching into the overheads that I have, given that you have this brochure which says what the goals are in this conference and what you hope to accomplish, and that you'd like suggestions for a research agenda. I figured I might as well take you up on that charge. Instead of starting with my slides, I'm going to tell you what I think might be a good way to go in terms of a research agenda.

First, I think spouse abuse should be broken down into different types. I'll just mention a few ways that one could do this extremely practically. You don't have to have a big matrix. You don't have to go into the kinds of things that I've suggested with multiple dimensions and this and that and the other thing. I'll give some concrete examples. You simply look at moderate versus severe, whether it's relationship-specific or generalized aggression. That is, does the guy fight in bars and in other places, or does he just fight with his wife? How long has the problem occurred?

As Jim Breiling mentioned, one of the things that we know pretty darn well from the research on conduct disorders and delinquency is that the longer a problem exists, the more difficult it is going to be to treat. So, if one simply asks in an assessment interview, or added it to something that you use, an adaptation, let's say, of the Conflict Tactics Scale, I think that would be very helpful. And that if you go to a conference five years from now, I would hope that every time a slide is put up, you would be alerted to whether we're talking about severe violence or moderate or minor violence.

I think we have done ourselves in. That is, I believe the professionals and advocates for family violence work have tried to argue how big the problem is. You hear stuff on the radio almost every few days. A person is hit every so many seconds and this and that and the other thing. When in fact, what is really being used in a lot of that data is how many times is there something like a slap, which is not what most of us think is what is needed in terms of significant amounts of dollars and efforts in terms of treatment. Why is it necessary to break this kind of stuff down? Well, I think the correlates and the causes differ, and I'll try to document that. And I think the treatment should differ. As Jim said, one size here shouldn't fit all.

Second, with regard to the causes of the problem, I think that research should be conducted which allows us to determine the relative importance of different causes or correlates. I think we're moving to a point where we know enough about risk factors, but we don't know enough when we're talking about moderate aggression or whether we're talking about severe aggression to be able to say, "What should we rank first?" I'll give you an example later, actually with some Army data, to give you a sense of a direction I think this might go.

As I heard Joel Milner give his excellent presentation, I thought to myself, "I basically could have used pretty much the same slides." All I would have needed to have changed was the label at the top. Instead of child abuse, I could have been talking about partner abuse. I should have said, "Joel, I didn't have to prepare this stuff. Give me your slides. I'll whip through them, edit a few here and there, and you'll have the same things." Now, why do I raise that?

I raise that for two reasons. One, Joel presented a lot of information about the causes. He can speak better to this than I, but I don't think in the child area, and I'm certain with regard to the partner abuse area, we don't have a good handle on which comes first, which is a co-occurrence issue, and which is a major thing about which we have to intervene? So, we need multi-factorial models to take us beyond these correlational and analysis of variance approaches where we are now.

While I'm on this comparison regarding Joel's presentation and my presentation, I think we are also in kind of a funny position. I decided not to say anything during the morning's conversation because I knew I was going to have a chance to get you myself. But, I think it's a bit ironic that we know pretty darn well that there's quite a good risk for aggression across one dyad to the other. We know that from civilian data. We also know that from Army data. That is, if a parent is abusing a partner, we know about the risk to a child and we know about the risk vice-versa.

But, what do we have in this country of ours? We have an agency, The National Center on Child Abuse and Neglect. We've got NIMH and other different federal agencies. The focus is pretty much on one thing or the other. We've got these different journals that Joel listed and generally, they focus on one or the other. Things are changing a bit now. We've got our own conferences. There are child abuse conferences

and there are spouse abuse conferences. Fortunately, at least here we're only divided by the 12:00 hour. But I raise this because I think at some point, there ought to be -- and I'm trying to convince NIMH about this -- that we should look within a family and look at the extent to which there are common predictors of aggression against a kid and aggression against another partner.

Now, to treatment. Well, I guess I can't say it any more strongly -- I was going to say convincingly, certainly more strongly than Jim Breiling, that we need to have emphasis on treatment evaluations. I have written several recent papers, and I'd be glad to give them to anybody here who wishes. There is no evidence that there is any single treatment for partner abuse that works any better than any other one, despite lots of protestation to the contrary. I will go into that later.

We need to have treatment evaluation as related to other alternatives including where possible ethically, no treatment. Or as in the case of the Navy, rigorous monitoring. In some work on depression that I have done, treatment research on depression, you've got treatment on demand. So if the person gets suicidal or they absolutely need it, they know that they're assigned to a control group, but they know that they can make a certain number of calls. They're included as your control. That's another potential option in this area. Obviously, there are sort of probationary or legal alternatives as well.

When it comes to treatment of partner abuse, there is no area that I know of where the problem of dropout is greater in any psychological or psychiatric treatment save one and that's alcohol. But if you look at anxiety, depression, you name them, any of the DSM IV categories, people don't drop out of treatment like they drop out of treatment for this problem. I think we have to ask ourselves, Why do they drop out? Even when they're mandated, they drop out at rates between 50% and 65% or higher. This is not just my data. Take a look at Tolman and Edelson's book. They review that literature and you have a dropout rate that's that high.

Well, one alternate is perhaps we're giving them something that they don't want or they can't profit from. Perhaps they don't like it in a group format. I'll come back to that later. Actually, we have data and that was the biggest predictor. Of about 1,000 people who called us requesting treatment services, the main reason for not wanting to avail themselves was they didn't want to be in a group with other people.

Finally, with regard to treatment, we need to know who can be helped and who can't. I'll just give you one example. In our most recent evaluation, what we found was that if you simply looked at the rate of physical aggression that occurred in the four months prior to the treatment which was then going to be four months -- so this is sort of pre-post in addition to the usual Conflict Tactics Scale given over a year period – the correlation between the rate of aggression prior to the treatment and what it was one year later was approximately 0.65.

Now, it's not that easy if you look at the psychological treatment literature or psychiatric treatment literature to find good predictors of outcome with a couple of exceptions. One predictor is the pre-treatment level of the problem, be it depression, anxiety or something else. So, I think it should not surprise us to learn that aggression, or the level of aggression is a major issue in terms of outcomes.

Now, I'd like to give you a sense with some data about why I think we need to address these issues. Well, I wasn't sure whether I should show this, but since I heard there were questions about, What is the Conflict Tactics Scale and what are you really measuring? Since, again, we've got our morning and afternoon groups apart, essentially the Conflict Tactics Scale and various adaptations of it are really measuring specific physical behaviors. Usually, people refer to the first four behaviors as what is the moderate level of aggression and the last four are the more severe (Figure 1). At minimum, as I said earlier, I think it's important to try to differentiate those.

I think that if we were to look at aggression against partners in a continuum where it moves from verbal aggression to lower level physical aggression and to the more severe levels of physical aggression, it would be helpful. First of all because, as I'll show later, there are different causes and correlates of each of these three types of aggression (Figure 2). The prevalence levels are going to vary markedly. So, for example, if you took something like verbal aggression, well, How many people insult their partner, call their partner names? Well, I mean, how many times in the past year did you call your partner a name? Well, you could say this is based on New York data. When I was calling 400 couples who were just engaged about 90% of them admitted to insulting their partner, calling them names and things like that in the year prior to their engagement. So, for whatever reason, people engage in these types of behaviors at extremely high rates.

But, what about physical aggression that's so commonplace? These are rough estimates and the first one is based on the Straus and Gelles nationally representative sample of some 6,000 people. You have roughly 10% to 12% of women in any one year that will say over the past year their partner engaged in physically aggressive behaviors like pushing, slapping, shoving and so on. If you look at young married people, like we did for the 400 couples that we got one month prior to marriage and then followed them for three years, about 40% of them said that their partner engaged in aggressive behaviors against them in the past year.

Now, again, I could say that when I've given this presentation or variations of it in different places they say, "You're from New York. We know that the mayors there have to instruct the people to be nice to visitors and get on these public relations campaigns for tourism in New York." I'm able to tell you that people engage in these types of behaviors in nationally representative samples, and it's not confined to New York. In one study, 40% of the people said they engage in these behaviors.

If you go to a marital clinic, it's obviously higher. I was not going to use this, but I decided after hearing some of these other presentations, I would. I won't have time

today to talk about our prevention work in high schools, but what I would like to say is if you just look at the bottom, the self-victimization by males and females, about 30% of males and females in high school in 11th grade say that their partners engage in those same behaviors reported on the Conflict Tactics Scale against them in the past year. We now have data on 3,600 kids and the rates are about the same. So, I simply wanted to mention that even as you move down into high school, you already have by grade 11, where we were doing our intervention, 30% of girls and 30% of the guys saying that their partners are engaging in those behaviors.

I guess while I'm at it, I should also mention -- because this relates to how you conceptualize the issue -- at the high school level and at early marriage level, significantly more females than males report engaging in physical aggression against their partners. As you get older, the rates get more similar. I think what happens is across time, as aggression gets more severe, fewer females are engaging in the aggression and more males are engaging in the aggression. But, I raise the issue about both male and female aggression because I think from a prevention standpoint, we need to have a sense about why this is occurring. We're now doing fairly detailed interviews with high school students about the context in which this occurs. We're trying to find out more about what the context is. Why do these girls slap guys? Why do they engage in physically aggressive behaviors against them, and vice-versa?

Oh, I need to also mention that at the high school level -- this is a bit disturbing -- we have 10% of males and 10% of females reporting that they had injuries themselves (Figure 3). Thirty percent of them are victimized, or are the targets and 10% of the kids are saying they had an injury. But now, let's go back to a potential clinical population and look at the more severe aggression.

In the young engaged sample, you've got a very small percentage of people who report this. In the community sample like Strauss and Gelles, you have roughly four percent. In a marital clinic, you've got 25 to almost 30% of the population saying that they are the victims of the more severe types of aggression. Given that, it seems to me that we then need to think about the fact that we couldn't begin to address the problem of every person in a service branch who has aggression, at least on any intensive level. Because, as Ed reported to you last night, you've got rates that are pretty much the same as they are in the civilian sector; perhaps a little higher on the severe end.

Let's say you roughly have 30% of your force, or even a little higher, that is in a situation characterized by physical aggression. I think that's a pretty fair statement to characterize where things are in the Army and the civilian sector, or in any other branch. But from a policy standpoint, you can't intensively do something for 35% of the population. So, a question is how do you break it up? Where do you focus your efforts to address the issue of those research goals? Because one of the goals said, What's the research agenda? And, What's going to be cost effective? How are you going to effectively spend your bucks?

Well, if I can take just a few more minutes to give you a sense of how you can conceptualize it, you will see a little bit of an overlap with what Joel presented. If you simply look at verbal aggression like insulting, yelling, name calling and so forth, we know pretty well that the biggest correlate is marital discord. The need to control misuse of power as represented by some dominance types of scales and jealousy are also correlates. They seem more important for men than women, but they're not major factors for everybody.

But, as you move up and you look at verbal aggression as well as physical aggression, since the phenomena is cumulative and you move from one to the other, you have these correlates, marital discord, the need to control and so forth, as well as these other things now in operation. You're more likely, if you actually engage in the aggression compared to just being verbally aggressive, to have seen it as a kid, to have been abused, to have some aggressive personality style, and to report a problem with alcohol abuse.

If you go the full length and you move from verbal to physical to severe, you're more likely to have those initial correlates and causes as well as clearly having some personality disorder, some emotional liability, and poor self-esteem. So that's a rough way to characterize the differences between the levels of aggression and the correlates or causes which, in turn, relate to, Well, what do you do about it? Given what I said before, this doesn't give you any sense of what's more important than something else. You've just listed a bunch of things that are related or are correlates.

In a sample of Army men, if we looked at odds ratios and looked at the factors above, not that they're all -- and I'll tell you some ones that I think we should have had but didn't -- the risk factors break out like that in that order. That is, marital discord had the highest odds ratios for being severely abusive, having a self-reported problem with alcohol, then drugs, reporting depressive symptomatology, being younger, and your spouse having concerns about the housing that she was in, the post itself. The level of financing was also a significant predictor, although not as high as the ones above (Figure 4).

So that I can give you more concrete information about this, in terms of the odds, if a person is discordant and you look at levels of discord, for every 20% increase in marital discord the odds of being severely aggressive increased by 183%. Whereas, let's say, to move down to something that wasn't as big a factor, depressive symptomatology or spouse concerns only increased the odds by 11% and salary, 5%. I raise this not because it's the end all and be all kind of study at all. It was a study done in the context of a needs assessment and it was a study done in the context of where you spend, essentially, an hour or less with personnel. Some of the issues were obviously to address concerns of the particular post like housing and so on.

Are there other factors that perhaps should have been in or that are important or could be important in terms of prediction? Well, one obvious one and perhaps the most

important if you think about what can you do about it, is not simply to look at general levels of marital discord, but to look at the levels of psychological or verbal aggression. Because, we know from our longitudinal research, if we're looking to see how those physical aggressions develop across time in a relationship, if we take couples where there was never an instance of physical aggression reported in one year and then look at them the next year, if they were at the 80th percentile on the verbal aggression score, there's a 75% likelihood of being aggressive the next time.

Since I spend one day a week in a clinic and have for, essentially, 30 years, I'm always interested in, Okay, what does all this research mean for what I'm going to do? Does it have any relevance for what I have to do on a day-to-day basis when somebody comes in the facility? I would say, Yes. That finding alone tells me that if I can work with a young couple, or you can, or somebody on your post can, and you can reduce the level of verbal aggression from a preventive standpoint or even from a secondary prevention standpoint -- that is, if a couple comes in and they are engaging in the moderate to mild levels of aggression and perhaps both of them are engaging in it as 75% of them do that come to our facility. If you can change the level of that kind of aggression and, in turn, change discord and so on -- but particularly, discord -- presumably, you could have a fairly significant impact.

Now, in terms of treatment, what are our options? What do we know? Well, at the top I've put what is the predominately used option which is a gender-specific program for men. Meaning that men are seen by men, usually in a group. The emphasis is primarily on issues of power and control and misuse of power and control. Then you have gender-specific treatment for women which is usually supportive therapy and, at least in the civilian sector, those two are generally not linked at all. Often, women get help and the men maybe are mandated to treatment and in 30 to 40% of the cases, they go. So, often the women get gender-specific help or supportive counseling, supportive therapy, but their partners get nothing but a mandate to treatment. Now, in the military, obviously you can do a better job because you've got a stronger arm on him and you have the ability to monitor them and you know where they are.

You've got physical aggression couples' therapy meaning that you treat them either in a group as a couple, or you can treat them as an individual therapist, as a couple. You've got individual therapy often for problems, let's say like depression or their aggression. You've got drug treatment which, as Jim mentioned, is perhaps something that will be pursued more often because of the purported concern between depression and aggression. There are studies looking at whether you can give people anti-depressant medication, particularly the serotonin re-uptake inhibitors, as a way of dealing both with anger and with aggression towards their partners.

Then, there's also the issue about various sequences of treatments. So, for example, based on one of the meetings of DoD last year, there was a recommendation, particularly for people that are mandated to treatment, that they get some kind of gender-specific treatment first that might be followed by couples' therapy. You have lots of other

alternatives as well. Some people might get individual therapy before being in couples or a group or what have you.

If I could just take the last three to four minutes that I have and go back to the issue that Jim raised. What do we know about the effectiveness of any of these interventions? Given that this is one of the research areas of my own, I must say somewhat apologetically that I don't think we know a heck of a lot in the kind of sense that, let's say, the American Psychiatric Association is looking for when they ask for exemplars of what are called empirically validated treatments. You ask yourself, Are there at least two, perhaps three or four different studies which produce the same outcome and show that same outcome relative to, the American Psychiatric Association? It's often a placebo group, not so relevant here, but an alternative treatment, a no treatment control, or a treatment-on-demand. We just don't have that in this area, or if they exist I'm not aware of them. That's troublesome from a policy standpoint because the question is, Well, how do you spend your money? What are you mandating people to do? What are you even suggesting they go to?

Well, I think one way in which the Army could be of great service, not only to yourselves but to the whole community at large, is that you have excellent opportunities to do treatment evaluations that I think could be done with small amounts of money. You could focus on particular posts or a series of posts and look at a certain kind of treatment in one situation, a certain kind of treatment in another -- a treatment for, let's say, severe people on one situation or severe and mild, but perhaps different treatments. Because you hire the people, you train the people to do the interventions. One of the most difficult tasks that these guys at NIMH have is trying to have some treatment which is adhered to, which is followed.

You have an excellent opportunity for that. I think you have an excellent opportunity also to be able to look at different options for different people. Here, I asked permission to cite in a study a table that was presented by Al Brewster at one of the last DoD conferences on spouse abuse and the treatment of spouse abuse. In that table, he outlines the different services, about ten different types of services, that are utilized by people in the Air Force when they come in contact with the FAP organization. He emphasizes that often, two to two-and-a-half different services are utilized, not just one. They range in terms of frequency actually from the most likely used service being marital service. Things like conflict management, anger management and so on down the line, with about six percent, I think, being removed from the home.

What we don't know, I don't think, is how effective are they? To go back to my first point, how effective are they with different levels of aggression? I think I differ with Jim Breiling on only one major issue that he raised, or at least I would say that we should be cautious about. I'm not sure we know so convincingly yet how easy partner abuse stops. We're a long way from Lenore Walker's 1979 piece that once somebody slaps somebody, it always escalates. We know for sure that's not true. But, Jim was referring to the Navy project and I think particularly, to the rigorous monitoring when he was

talking about whether these people could continue to engage in the behavior. I would ask you to consider that rigorous monitoring is a fairly strong intervention, or potentially a fairly strong intervention in the context of a Navy domicile.

I'll be a little more specific. At the last family violence conference, following the presentation where I was asked to be a commentator about the Navy project, I was told that from an organizational standpoint, letters were sent to each person when they were assigned or involved with FAP. They were told that in essence, you had to complete the program before any reassignment. Now, if somebody said to me, "Dan, before you become a professor -- while you're an associate professor, let's say -- if you hit your wife, you're not going to advance in rank or you're not going to move on to the next place," I'd probably stop if I were doing it. I don't know how powerful that was, but it has been confirmed to me by several different people who should know that the letter was there and there was rigorous monitoring. So, all I'm saying is that perhaps the Navy, in some kind of inadvertent way, found out a powerful intervention in the context of their full service provision, advancement in rank and so on.

Why do I raise this? Because I'm not as confident as Jim that aggression is so easy to stop. I know, as I said the other evening, that if in a young family, a young couple, if it occurs on two occasions, pre-marriage and 18 months, there's about a 70% likelihood that it's going to occur again. So, if we know it has been repeated, I think we should be cautious to think that it's going to stop. And that, perhaps as I said, they have an excellent way to help people stop in the context of a non-psychological intervention other than the rigorous monitoring.

DR. BREILING: I want to clarify about the rigorous monitoring. The recidivism, particularly the serious recidivism, was the same for all the groups including rigorous monitoring. Rigorous monitoring had two distinctive impacts. First, in the short-term the women improved dramatically in a number of areas, but that faded out. Second, the rigorous monitoring group was very, very high (I think by almost three to one) in seeking outside help.

DR. O'LEARY: I see. So, in addition to having the psychological intervention of checking with them each week, in some fashion or another, they were actually seeking out services.

DR. BREILING: Right. But we show that the recidivism is the same.

DR. O'LEARY: Right.

DR. BREILING: But there's something going on that really boosted the women's esteem in the short-term , lowered their depression. Perhaps, it was the effect of having somebody who's really stepping in on your side.

DR. O'LEARY: Jim, was it somebody from the FAP program or it was an independent person that was making the calls?

DR. BREILING: The FAP program.

DR. O'LEARY: So, when they called in if anything was wrong they could have asked, Where may I get help?

DR. BREILING: Correct.

DR. O'LEARY: And they would have been referred. So, in essence, perhaps that rigorous monitoring was both rigorous monitoring and referral assistance. This would actually make my point even stronger that it wasn't simply, Let's just watch and see what happens.

DR. BREILING: But it made no difference in the recidivism. They did no better than the other groups in the model.

Spouse Abuse Research Discussion I

Moderator: LTC Ann E. Norwood, M.D.

LTC NORWOOD: Thank you, both panelists. We're due to have a break in ten minutes. Let's start with a few comments, ideas, honing to the Army and the unique opportunities for research that we should consider doing. Comments, questions?

DR. MILNER: Just an observation. Last night when the overheads were presented and we had the topologies or categories for spouse abuse, rape was not mentioned and it wasn't mentioned in the presentation today. I know that in a recent Air Force funded review of literature conducted at New Hampshire, they indicated that the greatest threat of rape for a woman was from her husband. Thirty percent (30%) of all rapes were by the husband. I'm just wondering why we're not discussing that?

DR. O'LEARY: I'd be glad to respond. We are collecting data on this. In fact, there's a fairly large study of about 350 people assessed by a woman named Dina Vivian, 350 couples. To her surprise and her co-investigator's surprise, the level of what would be considered rape by New York State legal definitions was extremely small. It was around 5 to 7% in a sample of people where physical abuse was the presenting problem, or physical aggression was at least part of what was seen at the initial intake. Now, on the other hand, if we go to our county facility where usually people come via the police, then the rates get to be something like 20 to 22%. So, I think there's a big difference, again, in terms of what populations one is referring to. When one is dealing with the most severe aggression, you tend to see a correlation.

One of the people working with me for a Masters' level project wanted to look at the association between physical aggression and sexual aggression, particularly rape, but in fact was foiled because the rates were so low. I contacted Dean Kilpatrick because I was concerned, "Are our rates really that low?" He said, "No, if you actually look at a representative sample, you have relatively low rates of rape compared to rates of physical aggression." I think Joel's point is a good one and it addresses that larger issue of how much are we all guilty of dealing with our own little bailiwick? In my case, I deal with partner abuse (usually physical), not so much child abuse. There are rape centers in our county that deal with rape. Then there's a separate center for physical abuse. Here, again, all of these little pies are divided up and perhaps in an unfortunate way.

DR. BREILING: I'd agree with that. It's one of the things that's real clear from the crime delinquency literature. People, in general, do not specialize, they have a wide variety of behaviors. What happens is that they move among the systems. If they weren't in one system, they were in another. They were in the psychiatric facility, they were in the correctional system and so forth. Once again, it boiled down to a small group cutting across these systems that was accounting for an enormously heavy cost. Rape overwhelmingly comes out of the deviant behavior syndrome. The intervention for this that is most powerful with adolescents, for example, is intervening with delinquent peers – just as it is for delinquency in general.

By the way, to underline Dan's point about the problems with studies that rely just on a few variables and then people pick them up -- it's really important to cover the waterfront in terms of variable and to factor them out. Take adolescent sexual aggression, for example. There was a very high correlation of its occurrence with attitudes supportive of rape. However, when you put in the array of variables including the delinquent association with peers, the attitude measure dropped out as being significant. It is the delinquency measure that underlies all this and is the key focus.

The same thing emerges with violence being associated with a high rate of illegal drug use. People say, "Ah, it's the illegal drugs" -- although that doesn't make sense because there's very few drugs that cause violence. But, when you have the comprehensive measures as the McArthur risk study recently did with 900 people followed up, and you look at the Bob Hare's psychopathy measure, lo and behold, drug use is no longer significant and is accounted for by prior longstanding, high levels of anti-social behavior. We know from longitudinal studies of delinquency that those who persist in delinquency and criminality diversify into drug use as well.

Now, there is a group that goes into drug use without a history of delinquency. But those who persist in long extensive antisocial careers overwhelmingly become involved in drugs, however, the anti-social behavior occurs first and underlies the drug abuse. So, it's really important to ensure that all appropriate variable are included in the analysis.

One last thing on Dan. I knew a lot of what Dan was going to say so I tried to really set it up! Verbal aggression is a really good focus for a Stop It Now and Come In program because it's acceptable. It's not stigmatizing yourself if you say you have marital distress. Early intervention potentially has enormously important preventive implications in terms of escalations as well as in the reporting of spouse abuse. We have some data that suggest that observing parental conflict and so forth can be as harmful as some of the direct energy stuff that happens to kids. If we're going to reduce kids' exposures to these verbal arguments and things that escalate, we're really doing something important for kids as well as for the couples. Rather than advertising and saying, "Hey, if you're clobbering your spouse and you broke her jaw or something, come in", just say, "If you're experiencing marital distress, shouting and screaming at each other, and would like to find some ways of reducing this, we can help."

Now, if people volunteer, you have to be able to offer acceptable and reasonable treatment that pays off for folks. It really makes the system accountable. There are enormous payoffs. This kind of program could be easily and quickly tested in open clinical trials on small bases and at a very modest cost, not the $5 million San Diego program.

LTC NORWOOD: Before we stop for a break, did you have a comment, Colonel Mays?

COL MAYS: Yes. In reference to what Delores said, there was a question about the apparent lack of discussion about rape or marital rape as either a policy statement or in the statistics presented last night. I was going to make a quick comment. On the clinical side of the house, we use a form that categorizes the nature of the abuse when we're doing our intake. That form goes into the Central Registry. There is no discrete category for rape. It would be clustered into severe abuse. When we're staffing that case relative to whether or not we're going to substantiate, we may discuss the type of conduct or behavior that occurred up to the issue of whether there was wanted or unwanted sex. There's a criminal statute within the military that classifies rape. I think we might use those standards as to whether there was threat to life and so forth.

Some persons on our case review committees are willing to define rape as the victim or spouse saying "I didn't want to do it. He made me do it. I felt intimidated. Just to get it over with, I did it." Then I've heard people say, "Well, you've been raped." Then off we go with a clinical definition, not a criminal definition.

Delores, I don't know if you wanted to add anything. Or Colonel Lockett? Does that answer your question? It's not an omission by intent.

Spouse Abuse Research Discussion II

Moderator: Robert J. Ursano, M.D.

DR. URSANO: Welcome back. We're now in the home stretch. This is where you take out all of those weights you've been carrying in the saddle and dump them, and you begin your rapid gallop rather than the slow trot as you head towards the witching hour. The plan is, first, we are going to focus now on the question of spouse abuse. We're going to focus on the question of a research agenda for the Army, making use of the outstanding presentations that we've had. They were really just superb.

I want to give Delores the first shot at commenting -- to remind people of what the Army is already doing, or DoD is doing, and of what are some of the particular problems that you are concerned about. We can then apply the database we have just received in thinking about the research side. I also want to alert you that during the last 15 minutes, I will go around the whole room and ask each of you to provide either a comment you wish you could have made all afternoon, or a comment on what you think should be the priority item for research in spouse abuse and child abuse. So, think about that while we're going through and jot down, or keep in mind what it is you may want to make sure we don't forget. It's the chance to make sure we've got everything on the table and that we haven't forgotten something. So, Delores, take five minutes and respond to the data that we have heard and also to the, "Oh, my goodness, this doesn't address problem X," which is the one you're hearing the most about.

MS. JOHNSON: I'd just like to add to your comments about how on target I think the discussions have been today in terms of what we had anticipated happening here. I think, just for everyone's benefit, that we have made some effort to try to standardize the approach that we take in spouse abuse. I guess two years ago, we trained -- or Bob Geffner trained for us, the clinical practitioners in our medical treatment facilities on doing assessments. We stressed how critical it is to do very good assessments and begin to try to tailor our treatment approach to the kind of abuse that was occurring. As I'm saying that, I'm thinking, "But we did not change what we do." So, there's a big disconnect in that. I think we do a better job of assessing. We just don't have any variety of treatment programs to put people in. We do pretty much, at most places, anger, anger management, or male gender-specific groups that look at power and control, the same thing that other people do. It's a very short-term focus. That training forces people to think about doing longer term follow-up to those 12 or 16 weeks that is just initially offered, particularly to the male batterers. We have the same problems that everyone else has because we can not mandate the spouses into treatment. We can not hold them there. I think that's pretty typically what the Navy research showed as well. Even when you're doing couples counseling, it's really not couples counseling because the spouses don't come. Or they come and they drop out at a very high rate, probably somewhere after the second or third, fourth session. So, it's nice to have validated some of the things that we've been thinking about as being real problematic.

I was listening to Jim Breiling and jotting down everything he said about identifying the risk factors and having an intervention method. One of the things I guess I'm thinking about is that we -- we, meaning the Army -- have a really wonderful opportunity here to develop some labs -- maybe just one, but maybe two --where we can

build a model family advocacy prevention and intervention efforts and have people get on the ground with us early to study that. And then to use those as ways to identify best practices, training, materials and information, and then import that to the rest of the Army. I think, as I've been listening to everybody, that there could be a collaboration of several different university systems and researchers to focus on those issues and narrow it down and try to send something over to Peter and have him take a look at it. I think we're ready for that. Is that my five minutes?

DR. URSANO: Sounds about right. The floor is open. Let me, just to add some comments to make sure we stay on track. We want to target the subject of how to deal with commanders. They will ask tough questions of any researcher who shows up at their door. Speaking as a commander -- and I'll put on a green suit for today and say that I am the Army colonel, commander of the post. What I heard this morning was that if I take all my people with anti-social personality disorder -- of course there shouldn't be any because we should have already cut them out since that's an exclusion criteria for being in the military. But, if they have anti-social personality disorder, I can already kick them out. So, number one, I'm going to kick all those people out. If they have borderline personality disorder, that's also a reason for removing them from the service, so I'm going to kick them out as well. So, how much of a problem do I have left? Tell me, by the way, how many people do I have left as well? That's number one. I'm serious. That is exactly what I will hear.

Secondly, I understand that the best thing I could do is rigorous monitoring. In fact, I understand that Army R&D is really interested in telemedicine and tele-communication. I'll bet that we could probably get about $14 million in order to put together a satellite-connected system that allows me to constantly keep track of where the spouse is and where the abuser is. I might even be able to get monitors for tracking them with an alarm system that went off, say, if they were within two feet of each other. I would know instantaneously and send in my SWAT team. That SWAT team would be armed in order to manage this difficulty. So, is that kind of monitoring system that you're suggesting and would that, in fact, solve my problem? Now, the answer to both of these I'm looking for from this audience is something about where is research going to tell him which pieces of that story are right, and where is research going to tell him which pieces of the story are wrong?

COL LOCKETT: If I could add just one more piece from the commander's perspective? As the commander, I want to have a better sense from the clinicians that when they notify me that my soldier is involved in spouse abuse that, number one, they are going to do a very good assessment. So, when you tell me this is the problem, these are the ways you're going to intervene clinically (which includes educational, couples, spousal, or whatever) and I agree to support this and I agree to encourage the soldier's spouse to participate, and I make a commitment that I'm going to have to give this soldier up -- because sometimes it's still viewed like that by the commander – for 12 weeks or 20 weeks. At the end of that period of time, I want to know what are the outcomes I can look for? What is it that you're going to be able to tell me in the report back to my first

sergeant, back to my company commander, that I can expect that now. Does this soldier have some different ways to cope with his anger, his aggression? I would like to know that he has tried out some new behavior. I would like to know that the family has been involved, what can expect and what I can't expect.

As the commander, I want to know from you as the clinician, after you've seen this soldier and/or this couple and they have been in treatment and you've tried these several interventions, I want a recommendation from you as to when cut the line. I need you to be able to tell me, should I keep sending this person week-after-week-after week? I want an assessment from you. You're the clinician. I made the investment. I support you. I support the soldier coming. But now, I need to know. I don't want to carry this soldier on and on and on. If you think this is going to be continued, repeated behavior and it's going to continue to be a problem for me as the commander, and when it comes time to deploy I can't count on this soldier because he's going to get called back -- I need your good, best judgment as a clinician who's been involved and assessed this situation, what's your recommendation to me as the commander? I don't want you to just tell me, "Well, sir, you're the commander so it's your choice." I want a sound, clinical recommendation. Where do we go from here?

DR. URSANO: Bob?

COL MAYS: I know that some of our data tend to suggest there are peaks and valleys of plainly experienced episodes of abuse across the Army -- redeployment from certain missions, pers-tempo, op-tempo. I'm wondering if that has been empirically validated? If I have a mission, a deployment to Rwanda, can I expect a certain level of abuse to occur within my unit? Are there interventions I can take, packages you can give me that might reduce the incident rates? Also, I understand that perhaps there are incidents related to PCS [permanent change of station] moves, that in the guest house, both coming and going, they tend to have a higher rate of abuse. Is that empirically validated? If so, what measures can I take? Does sponsorship reduce the rate – people know where they're going and –

DR. HAMPTON: I've not heard anyone comment about whether there are differential rates of violence between types of units? I don't know if there are data.

COL MAYS: I know that's been looked at. The question was, Are there differential data by units and missions? Do combat, combat service, or combat service support units tend to have higher rates? I think that there are no significant differences, but perhaps the rates of abuse occur more in our combat service support units, our clerks, our cooks, and those people who are more apt to be involved in the daily labor more frequently than others. We know that's true in the military correctional side of the house, that those units tend to be over-represented in the military justice system. I worked in a correctional unit for four years and there were more cooks, clerks and those types of folks in jail than others.

We have also discussed from time-to-time that people who are involved in special operations such as the Rangers, Green Berets, those who use direct application of force, are more trained as to the opportune time and the appropriate use of force and, therefore, are more apt not to use violence in their relationship because they are attuned to when and when not to apply force.

MS. JOHNSON: The closest data we have to that would be the assessment data that was done at the installations. There was a question about units, but I can't recall now why we didn't analyze the data. We could probably go back and take a look at it, but we just didn't. There was some debate about what value that would add overall. We are asked that question a lot.

DR. NEWBY: I think that units may be a surrogate for something else, and that is, Where do those individuals who typically get assigned to those type of units come from? Where do they come from, in terms of their recruitment, or when they volunteer and come on active duty. I would think that if you're a cook, your chances of being assigned to a certain type of unit would be much different than if you have a different type of MOS [military occupational specialty]. So, I think the unit may just be serving as a surrogate.

DR. BREILING: If I could respond to a couple of these things? I think it's really important on your agenda to be clear about what research is going to be really productive and useful for policy and practice programs, procedures and what is not. For example, the unit question strikes me as not a very productive question. For one thing, you're not going to change your unit structures, so what are you going to with the information? The other thing is, we've seen in a number of areas, it's not the label, it's the process that takes place. For example, people say and the question has been, Does participating in college athletics foster date rape? First of all, there are all sorts of athletics. Are we talking about the track team, football team, basketball, tennis players, or what? Number two is, if this is going to vary enormously, what are the dynamic factors that take place there? One of the strongest ones has got to be the peer association and orientation and those are going to vary. Now, that's something that you can address and monitor and look at. Not necessarily the units.

DR. URSANO: Which, in fact, we have good data on in terms of drug abuse.

DR. BREILING: Yes.

DR. URSANO: And the drug abuse cultures, particularly during the time of the Vietnam era, was, in fact, the method for propagation of drug abuse.

DR. BREILING: Yes, by the way, the most powerful drug abuse intervention with kids is the feedback from the bulk of their classmates, even in the highest risk city, that they should not use drugs. So, you make clear what the norm is.

DR. URSANO: One of the studies you might be suggesting and would be quite interesting would be, What are the peer networks of those that are identified as abusers in the military? Go back and ask abusers who are their friends.

DR. BREILING: Correct. I think it's theoretically possible that there are a number of issues. Something that I think can be done at moderate cost, it strikes me, is to prospectively enhance the assessment at recruitment and intake in terms of certain personality features. Most of this could be automated for computer processing, scoring, and then follow up in three realms. Performance within the military – for example, highly anti-social folks are not going to be good performers over the long-term.

COL MAYS: It depends on the environment. You may want those very types carrying a rifle across the sands of the desert. They just have to be under proper control.

DR. BREILING: Well, okay, but let's. I'm skeptical, but let's see. Number two, their service use and demand, and number three, their family functions and problems. Let's see what happens empirically in the work-up.

By the way, you may have something. In a program working with severely disruptive problem kids, the services the kids were getting were not adequate. The services didn't make much difference, to put it mildly, in the kids' behavior outcomes. But, one of the things that was interesting was matching the settings. One of their success stories was this foul-mouthed obnoxious kid who they got to work in a fishing crew where he could curse all day and swear out on the water and it didn't upset the world because or create problems. But, I think this prospective longitudinal thing really needs to be done. Because, if you do have serious problems and you can identify them, then you can deal with them in certain settings and contexts in terms of what's appropriate.

COL MAYS: Or a discharge.

DR. BREILING: Or a discharge. By the way, my observation and all the feedback I'm getting is that it doesn't happen that often. It certainly didn't happen in San Diego. You asked a good question. You want to know what's going on the assessment. Clearly, the assessment quality now is irresponsible. People are not doing the basic things in terms of assessing differential needs and risks in terms of these characteristics, even to the extent of the nature of the violence. When you say spouse abuse, it's all over the lot from this mild stuff where people were arguing and it upset the neighbors, and drinking and they got called and hauled in, to the serious and chronic violence that goes on. There are enormously different implications there. So, there really has to be a sound assessment to come back because the majority of cases are going to be referral out of the system. Now, ideologically today, we're not going to get away with it as we would with a juvenile doing this mild thing. So, you're probably going to try to automate some quick little session that whips through this stuff.

For example, in my county, if teenagers are picked up for drinking, they are enrolled in a special educational program. It is also possible for them to lose their license or have it restricted to daytime driving. These are mild delinquencies, generally. But it's sort of like hey, no longer does the court want to say, We're just letting you walk and not do anything. These are low cost, easy things to do, that people feel good about. You feel like, Hey, something is happening. The court isn't just letting them go. But, the base rate is so low. All we want the program to do is not to do harm and have kind of public acceptance at low cost. So, that's where a lot of the people are going to go. The other is going to be the marital.

Now, the other thing they can do is to get to this criminal psychiatric group. That is going to be really difficult. It's done enormously inefficiently and not well focused. So, there are enormous opportunities there. The model can be laid out now, the specifications of what to focus on. What you can do as part of your clinical research practice, is to validate that. When you say, "Hey, I want to divert these people out", we see low risk in monitoring, 95% of them should not be back for anything serious. If you refer to the marital thing and say, "There is discord here", something should happen with effective treatment, and the same way with the criminal psychiatric cases. But, those assessments are not taking place. They need to be upgraded. Then, clinically they can be validated very easily again with moderate costs within your setting. Now, in terms of dispositions, it's very clear -- by the way, you know, it's interesting we got into this whole treatment area for criminal behavior and the spouse abuse area when we're saying in criminality, generally nothing works.

Kind of strange. In fact, some things do work. It's clear from the delinquency literature. It's clear from the adult literature. But it's not what people typically do. You've got to do things that hit those needs and risk variables. As the Canadians have shown in the adult area I think, you've got to focus on the high-risk folks if you're going to have an impact. You're not going to find a cure for pneumonia dealing with common colds. You've got to go for where the problems are. You're going to have to deal with the real focus there. That is not happening. It's not going to happen starting with groups. It focuses by saying, What's the problem? Then, How are we going to impact on that problem? When you lay that out, you worry about the modality. But that's at the bottom of the pile, not at the top of the pile. Anyone that says groups right away, run through the door and think "marshmallow enema." So you could restructure and do things and it would make a real difference there.

MS. JOHNSON: You know, several years ago we thought that we should have a one-time session for a lot of these low level folks that we were seeing. The clinicians were all saying, "Not everybody fits this category." What you get is a lot of clinical inertia once you actually start doing that because you're very afraid that the people that you do that one-time thing for are going to come back and create this horrific incident. It's a little bit more complicated and the clinicians really have to struggle with that because the commander is still there saying, "I thought you told me you fixed him. You said he only took two sessions or one sessions."

DR. BREILING: No, we're never going to say we've fixed him. We're going to say that we're going to make a disposition and there is some risk. Now the fact is within that group, in fact with delinquency, you can predict that some of these kids will be back into spouse abuse. And the fact is, that's one of the tests. The people walk out the door and they feel comfortable enough to call back. I don't know anything in the mental health area that we cure. We reduce symptoms. We manage. Why would it be any different here? So, if you're dealing with a problem like this, if it reoccurs, you want to have people comfortable seeking help. As I understand the objectives in the marital area, that's what they're saying. It's not realistic that we would cure things. We will deal with the pressing problems now. Okay, we'll check and you check, and we call or we deal and intervene. The same thing would be here. But people have to be comfortable. They have to be treated decently. By the way, a big research focus is, What is consumer acceptability? Are they treated pleasantly? For people who teach in family group homes with the kids, to get recertified, they are rated on a scale of seven. All the kids, on average, have to rate them six or better for concern, for fairness, for regard, for working well with the kid. Why not the service people as well? Are your people coming in? Just a consumer evaluation service to get it up to date, are people treated with dignity and respect?

DR. URSANO: Dan?

DR. O'LEARY: Yes, I was just going to follow up on a point that Delores made having to do with the possible one-time intervention. Even if one didn't do a one-time, which I certainly understand, if there were a site or several sites where you could emphasize voluntary participation for people that are still at low levels of abuse -- before they are mandated -- and advertise for people who are having problems in the conflictual situation. I think perhaps I didn't mention this in a concrete way, but when we advertised our treatment project, in a short time, we had hundreds of callers because it was focused on people having problems of aggression, verbal fighting, particularly, but sometimes physical aggression in the relationship. So, people will seek out that service. I think Jim was even saying for some other more severe problems, they'll seek it out if it's done in a particular way. But, to be more concrete in terms of a research focus, I think that the Army would be in a great position at a post or two, to evaluate some of these alternatives that would get at the mild to moderate levels where people would volunteer, not be mandated --

MS. JOHNSON: Well, what you're suggesting is what somebody said this morning, and that is, using policy to force a change to see what reaction that would mean. Essentially, it would mean somehow coming up with some criteria to eliminate the very mild level from the definition so that people would not be mandated. I mean, that would be a real significant policy change for us. But it's possible. I mean, what we would do is then make them essentially "prevention" and probably secondary prevention, and focus on that. We could somehow make a much more distinct definition with specific criteria about what's moderate and what's severe.

DR. O'LEARY: Yes, and you know, you wouldn't even have to change the definition. Even if you kept the definition as it is, but you advertised for people who have marital conflict, all I'm saying is, at least based on-

MS. JOHNSON: It's a bureaucratic kind of thing, yes.

DR. O'LEARY: Are you saying you'd have to mandate them, each and every volunteer?

MS. JOHNSON: Well, everybody is mandated now by regulation, so it's a paper drill.

DR. O'LEARY: Even if they volunteer?

MS. JOHNSON: Yes, so I would have to --

COL MAYS: No, not volunteers. A volunteer could come to, say, another aspect of the medical system: social work, psychology, psychiatry, and work on that marital problems.

DR. O'LEARY: So, they wouldn't have to be reported out?

COL MAYS: They would not have to be reported unless they -- in child abuse, they would have to report an act of that violence, a spouse is more nebulous, but the model is like the drug and alcohol program, if you remember the old track one, two, and three. Depending on the grade you had in the military, for E-1 through E-4, for a one-time event, you could go into a track one education of eight sessions and there was nothing really held against you. If you were an NCO or an officer, it was a little different. I know the chief, General Reimer, had talked about the wish that we could have something like track one where a young couple, first time out, 12 months and had pushing, shoving, maybe some yelling, and that event would not necessarily mandate enrollment in a program. Is there something we could do where they don't become officially sanctioned? Because the issue is once you're in, you're looked at differently in the community and by your captain who doesn't want this happening. So, there's a stigma in a pejorative sense.

DR. BREWER: I think a track one concept will at least capture those people. They have a lot of concerns about self-referrals. I just don't see it happening. I think people, unfortunately, are concerned about a stigma.

COL MAYS: Delores, I remember you had come up with a title, I think "Couples That Need Services", sort of like in child abuse, "Children or Families in Need of Services." You're working with them.

MS. JOHNSON: Yes, FINS cases.

COL MAYS: Yes, FINS. They're a certain echelon, but they don't need the full work-up.

DR. URSANO: What was the other phrase, couples in need?

COL MAYS: Couples in Need of Services. I think they're calling them CHINs or CINs or whatever.

MS. JOHNSON: Families in Need of Services.

COL LOCKETT: Yes, but what that also would do for us, and for our soldiers and their families, it would remove one of the big disincentives of their coming in. Any involvement right now means you go into the registry. To frame that, I think we could certainly find out and test whether or not if we had a program like this and could establish the parameters for who could come into this, whether or not that really does remove a major disincentive for people seeking help to avoid having to be put in the registry right now. So, that would certainly be interesting to study. If we could do that at a couple of places, a couple of installations maybe to define that, this group, and look and see and test whether or not that really does make a difference. Because you won't go in the registry and that's important for a lot of these folks, they don't want to be put into the database.

MS. JOHNSON: But, we know a lot more now than we knew when we started this. I guess what I'm hearing, too, is that now that we're learning a little bit more about spouse abuse. Initially, we thought that one incident automatically, forever, meant a second incident, a third incident, and so on, more severe over time. What we're saying is that the literature now -- at least what I thought I heard today, is -- that that's not true. So, it would drive a changed policy decision and help clinicians get off the hook a little bit.

DR. URSANO: Some type of banner that could fly with -- you need the phrase which is big in the community. Something like "Be All You Can Be", but something that has to do with strengthening the family. Then underneath that is embedded all these other activities that don't necessarily have a negative connotation to them and are a very programmatic approach which stems from the Stop It Now, to the question of monitoring, to the question of further evaluation for true anti-social and borderline disorders with different kinds of interventions.

MS. JOHNSON: But, that would certainly be the kind of thing that we could sell to commanders to say, "Look, the research has now driven us to relook this policy." But we've got to make sure that it really is the right thing to do.

DR. BREILING: On the policy, on disposition, on severity and mildness, if we take the delinquency literature, most everybody who does a severe offense (aggravated assault or assault) the ones that are most typical have done loads of minor stuff and you should take it seriously. On the other hand -- and I would assume the same is true in spouse abuse. If you have someone who comes in because they've choked or hit somebody with a weapon or something, I would take that very seriously. They probably have done a lot before that. Now the mild stuff is not necessarily a guarantee. We know from the delinquency stuff -- and I think it's a reasonable extrapolation with spouse abuse -- that the bulk of

what people who are chronic and serious offenders will do is minor. So, they're going to be more likely to enter the system for minor offenses. So, you're going to have a proportion of people with mild offense who are really serious offenders. So you can not make a really good disposition. The base rate is going to be that they're just doing mild stuff. But, within this group is a serious group as well. So, on the basis of the mild offense only, you can not exclude them. You have to assess further.

This may be a very critical junction because we do know that many of these chronic people are really terrorizing their wives and are doing massive amounts of stuff and controlling them to the extent that it's very hard for them to emerge out of the system. One of the things you can learn, if you just keep your voice down and quiet is that, the police are not going to be called very often. So, if you've learned how to control yourself not to draw the neighbors' attention, which a lot of these guys do, you can really be a terror and you're unlikely to be detected. So, when that mild thing pops up, that's a real avenue for a quick, adequate assessment as to what's going on. There are questions like, Is the wife free? Does she have friends? Is she out on activities? Have there been other medical visits? I would suggest to you that in a very brief time, you could do a pretty good supplemental assessment to make a disposition.

DR. O'LEARY: If I could just make a comment about treatment? Because Jim set this up in a fashion to be, should I say, at least cautious with regard to whether we have any treatments that work, I would like to say although we do not have treatments that would meet the American Psychiatric Association or the other APA of empirically validated with, let's say, two to four different sites showing the same result with control groups -- I think to be fair to the people who have been doing treatment outcome research, there has been a reluctance to assign people to control groups of any kind. I'd like not to leave here with you thinking, "Oh, well, here's a person that spends his time doing treatment evaluation research and he says there's not a darn thing there." I think there are a number of good things there, both gender-specific and for couples for different types of problems that have shown reductions. Just to give you an example, Steve Brannen has done an evaluation. I've done an evaluation. We've come up with pretty similar kind of results. Edelson and Tolman have done the reviews of the more gender-specific treatments. There are reductions. The problem is, we have not been as aware until recently that some people reduce their aggression without an intervention of at least a systematic nature. So, we do need creative ways of looking at controls that are ethical and will meet with public acceptance and yet, let the field move forward.

I'd like to make sure that I don't come down too negatively. There are a number of studies that have shown reductions in aggression across time. But, because aggression is relatively infrequent, one year, at minimum, follow-ups are really fairly critical. So, it's not just, Did they stop during treatment? There are a lot of people who can report that. The question is, Do they stop during treatment and do they remain either at a reduced level? This may be a reasonable goal, for some to use the alcohol model. We may have to, though it's not often politically so acceptable, address the possibility that like alcohol abuse, we may -- at least with whatever we have in our armamentarium -- not be able to

get everybody to stop. But, there are a number of treatments that have shown that you can reduce or stop, but we need to take it a step farther.

DR. URSANO: Are there other variables other than verbal aggression that we know are reasonable indicators of potential violence between spouses, something other than this relatively infrequently occurring event?

DR. O'LEARY: Yes.

DR. URSANO: What are our best choices? What are the outcome measures in such studies that we should include other than asking people, "Has he hit you this week?"

DR. O'LEARY: Well, to go back to some of what I was showing, you've got the verbal aggression itself which is the most proximal thing to the actual physical aggression. You have a general level of discord. You have, at least for certain populations, misuse of power and control tactics. Tolman has looked at a measure called maltreatment towards women. Again, thinking of the mild and severe, this does not characterize, does not differentiate mild from people that are simply in discordant relationships, to many people's surprise. But for the more severe, the misuse of control is a fairly critical thing. Jealousy for some, but I think it's so critical for the some that it's important to evaluate. If you look at murder as an extreme, that's one of the common denominators that comes out. Police have been called about jealousy before. So, even though jealousy is not a great risk marker in terms of the likelihood of predicting further aggression, when you rank them all, when it's real serious as a problem, it's important to address.

LTC BRANNEN: History of alcohol abuse.

DR. O'LEARY: Oh, yes.

LTC BRANNEN: Pre-test/post-test also perhaps Dyadic Adjustment Scale as a measure of marital satisfaction. Those are common outcomes.

DR. THOMAS: Dan, didn't you say that you were agreeing with something Joel said about hostile attributions just the way you perceive the things outside of your marital relationships. I mean, I –

DR. O'LEARY: There's some evidence about that, but I think I'm probably in agreement with Joel that it's not a strong enough a predictor yet for me to say we're spending money. Isn't that what you were getting at as well?

DR. MILNER: Well, that's true for child physical abuse.

DR. O'LEARY: It's something you can find in some studies, but I don't think it's a big enough predictor here.

DR. THOMAS: That's a belief that's in this field.

DR. O'LEARY: It is, yes.

DR. THOMAS: -- that it somehow contributes or accelerates or moderates.

DR. O'LEARY: Yes, especially from Dodge and Coie's work with aggressive boys.

DR. THOMAS: Yes.

DR. O'LEARY: We're looking at it now in two different studies. It's not big enough for me to put my money on this –

DR. BREILING: Prior aggressive behavior. Certainly from the New Zealand study of Harry Moffit, it's the prior aggressive behavior which is consistent that past behavior is the best predictor of future behavior.

DR. O'LEARY: Right, that's – just to go back, you can take a fairly simple approach in terms of saying are the big risk factors are and you just simply get at severity, length of time the thing has been in effect -- pardon?

DR.BREILING: Cross settings.

DR. O'LEARY: And cross settings, yes. If you know that, you've got a lot in your bag to be able to predict –

LTC BRANNEN: About half of the women that have been physically abused in a relationship have been physically abused as children. About half of the men who have physically abused their spouses were physically abused as children. So, those are huge risk markers.

DR. O'LEARY: But, I would put a caution there again. That may relate, Steve, to the level. If we do our assessment in the county facility where they're mandated, we get almost exactly what you say. If I go to the clinic that I have, then I have a lower rate. If I go to a cross sectional sample out in the community, the rate is even lower.

DR. URSANO: We don't have – which actually, the Air Force was the lead in this kind of activity -- a health risk monitoring equation where one enters one's cholesterol, one's lifestyle, one's HDL and it comes up with, You have a 2.7 risk of heart disease over the next ten years. I gather no one has approached spouse abuse or even child abuse from that clinical modeling picture. Although we have all those factors and we do that for individual populations, no one has done it in a way to apply it to across populations. Is that a fair statement? That's the kind of thing the military would jump on. You know, the health risk appraisal. We've now got a spouse abuse appraisal equation.

DR. THOMAS: Child protection had an early risk assessment where you added up factors and divided by numbers and certain numbers pushed you into different categories. Right now, for child abuse risk assessment, it's kind of gone by the boards. They've gotten rid of the quantitative measure. I mean, people have identified all of these factors, but it always comes down to clinically weighting them and making a subjective judgment, you know, because there's always one that gets this way or that.

COL MAYS: I know Gavin Debecker has a number of scales that you're familiar with his work in terms of his work with the Senate, the President, Supreme Court Justices on profiles of likelihood of people carrying out threats to those figures. He told me that he had several scales that are factored on spouse abuse in particular. I believe child abuse, he's working one now. Also, work place violence as it relates to the probability of a domestic incident spilling over into the work place. I have the references somewhere at home and I'd be happy to share it with you.

DR. MILNER: Usually the first time that's done, they have good designs and the discriminant validity is great. Then he goes on to another sample to cross-validate and it's a wash.

COL MAYS: Well, they continue to add cases, and you know, I'm not touting his stuff, but I guess the sample basis is about 3,000 or 4,000 cases. They keep adding to it. So, the validity may continue to decline, but it's as good, I guess, as most predictors in an emergency room when you're sitting there trying to decide whether to send a family home. Do I send them into a shelter? Do I send the kid to foster care?"

DR. MILNER: Has the weighting changed?

COL MAYS: I don't know. I don't want to speak any more about his instrument. The notion sounded fairly reasonable if you've been on the firing line at 2:00 in the morning. If you've got, perhaps, a computerized database that is looking at 4,000 or 5,000 other similar episodes and as you enter each variable, the weight changes until you finish the scale. Then you make your clinical judgment supported by what you've got in your readout.

DR. BREILING: There's a research agenda and a practice agenda to build on this. Dan's analysis about the odds ratio is really important. But you see, clinical practices need to drift toward, really, minute variables and you've got to really focus on those heavy weights in the criterion which, it turns out, cuts it down. In the criminology area, if you look at predictors and recidivism, psychological variables are tiddlywinks, are minute. But, that's what the clinicians spend the great bulk of time on which is really just empirically very uninformed. So that odds ratio is really critical. If you're dealing with something that increases the odds ratio to 1.3, you know, you've got something. But are you going to give a Rorschach for that when you've got something that's 11.7? You go where the elephants are.

DR. URSANO: It's the type of model that actually speaks the commander's language. The problem you run into with that is that people then ignore it when you talk about things like what's the risk of meltdown from the nuclear plant versus eating peanut butter? Of course, the risk from eating peanut butter is much higher than the risk that your local nuclear plant is going to explode, but people disregard that fact.

DR. GORDON: I think the one comforting fact about assessment is that the more severe data don't necessarily make very good performance about histories and so forth. With a research study, you can probably get a better picture because you had confidentiality in those things. I was in Baltimore, the key studies actually interviewed the male spouse, male child abusers, physical abusers and gave them diagnostic interviews. Those guys lie, basically. We decided that the data just was of no value because we'd ask them about stuff and we'd ask the wife about it, and it's like talking about two completely different -- this guy never took a drink in his life – drunk every weekend -- it's good to have other sources of information about these guys

DR. O'LEARY: Absolutely.

DR. GORDON: -- rely on what they're going to say themselves.

MS. JOHNSON: See, I'd be concerned that that severe category being small already for us, as we begin to identify and be more clear about that group of people that we would be recommending to commanders that those folks don't stay and they'd be ejected. I mean, there isn't anyone who's going to recommend that if we look at them and we identify them better, that we would recommend to a commander that they stay. So then, what do we do with the civilian sector where we're really sending dangerous people back, and we know they're dangerous? How do we bridge those kinds of gaps? You don't have the same kind of support system in spouse abuse in the civilian sector that you could do with child abuse, where we could pick up the phone and call the child protective services and say, "This person is no longer loved and wanted by us and we want to send him to you. Will you take them? Here's where they're going to arrive." That mechanism is there, but it isn't there for spouse abuse. We do call the police and they're not really interested. So, we'd have some ethical dilemmas, I think, when we start looking at that group because I can tell you, that group will not stay once we get a fix on them.

COL MAYS: But only if they're recidivists. If they don't repeat, they stay.

MS. JOHNSON: Oh, but they repeat.

COL MAYS: Then they should go. They don't stay in the Army.

MS. JOHNSON: But, I guess that's the dilemma that we're going to have to deal with -- how do we help those folks to make those transitions? Because, in a lot of cases, they're going to go with their spouses.

COL MAYS: At 480,000 people, you can not do what you did with 900,000. You can't retain them. They've got to go if they are not performing the way they should. Now if they've done their act and they've not repeated, every commander will retain them.

DR. HAMPTON: But if they're performing well in their assigned task, you still –

MS. JOHNSON: Remember, we're talking about severe. We're not talking about the moderate-to-low level.

COL MAYS: Then if they do that act, they're going to be charged with the crime of assault. If it stays in our system of family advocacy, then they're not going to be relieved of duty and dismissed. But to be relieved, they've got to commit an act of battery with injury, broken bones and so on, then they're going to be seen in emergency rooms. The provost marshall will be there. The commander is writing Article 15 and they're bringing charges. So, they're court martialed out of the military.

DR. URSANO: Do we know what percent of our folks that are in the category of severe go to court martial?

MS. JOHNSON: No, we don't but it's very small.

DR. URSANO: That's an interesting --

MS. JOHNSON: I bet you that it's very small.

DR. GORDON: -- not happening. You get the guy out of the military because he beat up on his spouse and that puts his wife –

MS. JOHNSON: At more risk.

COL MAYS: I agree.

MS. JOHNSON: That's what I'm saying. That's going to be the ethical dilemma because our system is not going to tolerate for any significant degree that severe abuser.

DR. BREWER: It's a personal dilemma. It's a personal struggle for the clinician. But from the Army's perspective --

MS. JOHNSON: But they don't leave. The point is that either we don't know -- if they're so good at what they do that they're undetected. I mean, we catch them initially because some neighbor called, maybe. I mean, these are the guys that are very, very good at what they do. They are very terroristically oriented. It's not that large a population that we have in our registry that's severe, I don't think. So, it's like the tip of the iceberg and we know there are more of them out there. We're just not getting them all. And they

don't do enough for us to continue to keep them under surveillance and saying -- it's a real problem. The severe abusers are a real problem.

DR. URSANO: One of the important issues you may be targeting, Delores, is the need to think through decisions that are informed from research. The management of our present severe population and the interface between that and the judiciary system and the ethical issues contained -- given the data that we presently know about, recidivism in that group and the dilemmas that they cause the commanders. That's a complex problem with substantial policy implications. It could well be we're stepping on our own toes in terms of keeping people in that we should be getting out, partly because we haven't got our clinicians feeling comfortable with any of that. We don't have our judicial system linked in the right way.

CDR EMANUEL: At least in an operational settings, it's a little clearer than that. Some of the folks who fall in that severe category who have personality disorders and usually some sort of substance abuse, when they were in a position that the commanders knew about them and they weren't functioning well, they were looking to psychiatrists -- this is the way you do it as a psychiatrist in the military much of the time. Should we fire this guy or fix this guy? Because he could juggle eggs in a tornade, we need him fixed and get him back to duty. But, the folks they want to get rid of, they pretty much know that this guy has problems and they're just looking for your approval and the diagnosis. Then they can also have additional things they can point to as to why they eventually fired him.

But the problem comes when you're dealing -- when I was sitting on Family Advocacy Case Review Committee and I was talking to a general psychiatrist, he's already seen a lot of these -- so that interface between family advocacy and psychiatry, I think, is strained. I think that, in the sense of partnerships, and everybody who needs to be involved in evaluating the treatment in these cases, that's another major thing that has to happen. How do you get, really, people talking to each other and finding out what to do or how to make these clinical decisions? How do they interface with the command? Because the general psychiatrists would tend to say, "Do you want me to fire him?" He was in the dilemma that if you evaluated him and sure enough, he found evidence that they guy had a severe personality disorder, then he could administratively separate him. He may make that recommendation, but it really isn't the psychiatrist's decision. It's then up to the commander who may say yes or may say no, and then we're back to square one. If the commander already knows this is a guy he doesn't want to keep, then it's a done deal. If he wants to keep him, then what do you?

DR. URSANO: Exactly. Exactly those kind of issues, I think, highlight some of the programmatic issues contained in any research design where you include in one study, a liaison between the FAP office, the psychiatry office and the provost office. Does that, in fact, impact in a salubrious way on the outcome of your study? You might find that that would have a bigger impact than anything else if someone is getting the information.

LTC BRANNEN: I was just thinking that we're talking about men here. The prevalence rates of females are greater than males, which I've seen recurrently, you know, in the Strauss data. It reminds me of two phone calls I received very recently. One was from a post where 24% of the perpetrators were in substantiated mutual abuse cases and 11% of the cases substantiated in the past year were female perpetrators, same types of violence as males. The question came to me because they know I'm a researcher in this area. They were asking, "What can I do for the female abuser, not the victim?"

The second case came to me from an installation. It was not from the family advocacy. It was from the US Attorney's Office that had ten cases of abusive females who used severe levels of violence towards their male active duty husbands. They also asked, "What treatment approaches do you have?" Now, that's not politically correct for us to talk about that, but if you want to go into an area and identify an area that's in tremendous need of research, it is female abusers. I think that's something we lack. I know I've been treating in the Army for 20 years now and we just don't have it -- no one has it.

DR. URSANO: Let me raise two other issues that I'd like to hear some clarification on which I think hold promise for some research interventions. We haven't spoken anything about the children in families of abusers, although we alluded to it earlier in terms of the interaction between those two. What is it that we need to know about the effect on children? Is there any way in which the Army and DoD has the opportunity to study that group in a way that would be helpful to us? Secondly, and perhaps we should address it first because it follows on our present discussion, although I was somewhat facetious about the Star Wars approach to monitoring, I was only somewhat facetious. In other words, that's exactly the kind of thing the DoD would jump on with some vigor. Does someone have some thoughts as to three different types of monitoring we should be looking at. Does it matter? Does the telephone work as well as the walkie-talky? If people agree to have video cameras in their homes, is that better than having a telephone at your side? Or purchasing cell phones so the person can carry it around with them, or an automatic beeper that they push? Do we know anything about monitoring and its types and its effect on outcome?

MS. JOHNSON: The only thing I can think of is that it would not work across the Army. It wouldn't work with some units where their people are in secret assignments, missions and highly sensitive areas. So, we couldn't necessarily apply a monitoring system to everyone. The first thing that came to mind was –

DR. URSANO: I'm not sure, are we monitoring the perpetrator or the victim or both in these systems?

MS. JOHNSON: The way that it has worked in some communities, you're monitoring the perpetrator where you're putting some kind of -- particularly in child sexual abuse, you're monitoring the person, the offender.

COL MAYS: You're talking about when you have a restraining order and you --

DR. URSANO: No. I was specifically referring to the program that Joel was talking about.

MS. JOHNSON: No, he was talking about monitoring. Electronic surveillance is what you're talking about.

DR. URSANO: In the program in San Diego, are we, in fact, giving the button to the spouse and saying, "You call us when your husband is about to get upset," or are we putting something on the husband and saying –

MS. JOHNSON: The women's movement -- the shelter movement, the advocates have just come up with -- I can't remember the company, but they're talking about developing something for victims so that victims can also have a system. But some of the electronic surveillance stuff has been targeted toward the offender. I just don't know how it would apply across the board, particularly with highly sensitive positions.

DR. BREILING: These are things that you need to research. The Montgomery County [Maryland] telephone company now gives out free cellular phones to victims who have restraining orders. The idea is to call if the man is nearby. All these things really need to be carefully evaluated as to how they work. For example, they may not be particularly effective with what happens as a result, or what's associated with it. Let me give you an example of an arrest and, in criminology, arrest doesn't impact upon the future event. We had one police department experiment in Minneapolis which suggested it did. In the subsequent replications done more rigorously, have shown an effect consistent with the rest of the criminology. So, a lot of these things you can tell in advance are not going to make a big difference. It's what's going to happen in relation to it. So, arrest, itself, does not suppress. In fact, if anything, it increases the likelihood of the offender among those most prone to. But it does allow an entry for other things to take place, and that's true of the telephone. If nothing happens, what's the point? You know, that's typically what happens. We have a non-reactive system. So, what the system typically does – I have the Guillotine model, for example on probation, a guy violates probation. The only alternative is to say we're going to revoke it and send him back to jail for ten years. Well, the system is wrong to do that unless it's dire. So, you have to do another felony to get revoked and that doesn't make sense. You need to have consequences and responses in line with the behavior in the contexts that are doable and meaningful. Those typically do not exist.

DR. GORDON: A couple of comments. The monitoring systems, number one, they're used in the more severe cases like in New York which connects directly to the police station, so, they could have a couple of minutes response time. Those are generally for situations in which there is a restraining order and the couples are separated and the guy has a history of violence. You just can't pass it down for everybody.

DR. URSANO: We can.

DR. GORDON: I was saying about the first issue, I think actually, the military would be a good arena to look at kids who are in, but I don't know because this is a pretty new research area -- information is becoming available. It's very stressful for kids whether or not there are long-term outcomes. There are big sexual differences between boys and girls in terms of the reactions to family violence in the home. Generally, these situations have a lot of complicating factors. Take shelter populations. We have not only displacement of these families, but shelter populations have very low income. Historically, you have a lot of changes in residences,. So, it's very hard to disentangle a lot of these different effects. A lot of kids have pretty bad effects and we don't know exactly what's associated with that. One study said that kids found that they had very high rates of oppositional and aggressive behavior in boys, like 60% of that population had oppositional conduct disorder. But, I think in the military, again, you have a lot of these more complicating sorts of situations – you have a better look at the actual impacts of being in violent home itself.

DR. URSANO: It might be a unique area in which to contribute because of some of the stability of some of the other variables that are present. That's interesting.

COL MAYS: I had a question or a comment on that. There are teams that, based on the issues you discussed, are now willing or will actually substantiate the emotional child abuse in the event of a spouse abuse case where the child is in the next room and they heard and perhaps didn't even directly witnessed. But, based on the literature you've been citing we'll tack that on as an additional finding. So now, we have a person who is substantiated for spouse abuse and child emotional abuse. We know that has caused some disturbance among not only that couple itself, but the command. It might be adventurous for us to validate perhaps in our setting or I guess more definitely tell the field about the reliability and validity of those findings. It disturbs me. When I'm chairing these, I just sit there and -- did with it. The team has a right to poke away at things.

DR. URSANO: To really try and determine to what extent that's true?

COL MAYS: Yes, is that true? I mean, if I'm in the next room and I'm five years old and I heard shouting and -- particularly on the low end of things, not even the severe end. But in any situation where it's mild -- severe and it's substantiated, there are teams now that will substantiate emotional abuse of children in the home.

DR. URSANO: Really, as we were talking before about this idea of families now are something these programmatic elements really as a community-wide set of interventions. A very, very interesting set of studies.

COL MAYS: I don't know that a policy emanated out of your office or out of Medical Command. I think it's just professionals in the field adding on to the real professional --

DR. THOMAS: And it's a big thrust in the civilian community. We were talking at lunch about the indirect effects of what happens. Because you've got potential re-victimization if the parent is the non-offending parent is also the failure to protect parent in the case of child abuse. There's a lot of things that really need to be thought through before people jump on to, you know, tacking that on and adding it on. What's the purpose?

COL MAYS: In custody dispute now, you've got a child abuse allegation as well as a spouse abuse.

Maj LAWRENCE: Well, let me bring back into practicing position on -- listing here, especially since we got back to talking about the whole family issue. I'd like to comment on – made earlier. You know, this is family violence, but everywhere it is, it's always separated. You know, here is child maltreatment and here is spouse abuse. They're always separate conferences. Even today we were separated. It's a really important issue and I just want to share with you. As a physician, I think one of my greatest struggles is screening for these people. I can speak from an emergency physician standpoint, we really need help in how to screen for these families. I don't think it's just -- screening needs to be going on, screening for spouse abuse. Because when people identify the spouse, we already know that there's a large majority of these children who are victims. Or if they're not direct victims of abuse, we don't know what are the long-term effects from living in these families. So, I think what we were talking about earlier with the serious cases and all that is very important, but I think this is just as -- if not moreso an important issue for the whole spectrum of the family in the Army. It's to look at how can we screen to identify these families a little bit better.

We don't have good screening tools out there in the clinics. Your average practitioner is getting more and more pressure to see patients faster and faster. You know, it's like, Why ask even one question? I wish somebody could tell me one question that would be good. You know, one magical question that would really have a lot of impact and identify a lot of cases. Maybe you could probably, you know, sell it to us and we'll say, "Okay, I'll take the time to ask one question." But there isn't one question out there. But, I've also too, as a practitioner, wondered sometimes -- there's so many things that require mandatory screening. We have to ask when they've had tetanus whether they're in for a laceration or not. We have to ask them about their immunizations. We have to ask them about their past medical history, the meds they're on. We have to take their blood pressure, their pulse. Well, you know, I guess -- look at the statistics, especially for women between the ages of 15 and 45, I think the leading cause of injury is abuse, why aren't we routinely screening? Why don't we have to routinely screen? I mean, you know, when that's the leading cause -- more than accidents, car accidents, any other cause for a woman to stop in my ER for injury is abuse. Then some of these people have kids and we know that then they're being involved. I don't have any answers as to the research for there, but I think it's an area that needs to be looked into for screening.

DR. BREILING: If that could be a project to develop a computer-based questionnaire -- video stuff today is really popular. It could be certainly done on the offender side. People like it. It's efficient. They're responsive and it's a low cost thing once it's developed.

DR. GORDON: I just mentioned that there is a -- funded research who are screening for partner violence in medical settings. There is a physician in Texas who did kind of classic study about women who were in the gynecological services and she did a study. We have a study down in North Carolina which is used in the modification -- fairly brief instruments but there is one that had been developed in medicine --

Maj LAWRENCE: Yes, I mean, I'd like to see it but I don't think that -- come up with a good tool yet. This may be one that they're trying and --

DR. GORDON: You know, a lot of these instruments have like face validity. I mean, if you ask someone, "Has your husband hit you with his fist in the last six months?" – I mean, that has face validity. A lot of times someone won't tell you that. I mean, there's not much you can do to get around that. The way people attempt it is to ask a question a different way. So, basically, there's kind of a disclosure threshold and some people just aren't going to tell you. But, if there are instruments that are well stated and they can cover enough of the act, the people who are going to disclose will disclose. I think they're pretty successful. What is kind of scary to me, is that both that study in Texas and in our study, we find that about 15% of pregnant women have been assaulted while they're pregnant. A lot of times the target is the developing baby. That's a huge problem in gynecological services and I recognize it.

Maj LAWRENCE: The statistics I know are 25% of pregnant women have some abuse.

DR. URSANO: It's certainly a risk factor that we haven't actually heard today.

Final Discussion - Wrap-Up

Moderator: Robert J. Ursano, M.D.

DR. URSANO: I think it's about time for us to go around the table and let people comment on what they think we have forgotten, or the idea that you want to make sure we put in the report. It's your prerogative. It's the thing you want to make sure does not get lost among all the things that we've talked about today. Maybe we'll start to the right and work around. So that, Joel, you get the first couple of minutes to chat. What do you want to make sure that we remember for Army R&D, Army research in the area of family violence?

DR. MILNER: That's quite a question for basic research. I decided to go another direction and be very, very practical. This relates to the presentation last night and the initial discussion this morning about concerns about the rates for minor physical assault. I have an overhead, if you'll tolerate it. That's the old joke, the professor can not talk without a piece of chalk in his hand.

I have several overheads. The one I've decided to show you is entitled "Non-Case Related Factors Associated with Child Abuse Evaluations and Reporting" (Figure 1). There's now about 15 years of research. I actually have a list of the studies under each of these categories. We're not going to go through those. Most of these studies are vignette studies. They're based on the old Goldberg study that was done in '76.

Goldberg used a vignette and it was a scientific manuscript. Many of you know this study. The only difference between the two versions of the scientific manuscript was one was authored by John T. McKay, the other one by Joan T. McKay. They passed them out to professionals to evaluate. They looked at the originality, the quality of the science, how well it was written -- and other things, as you'll remember. They got the evaluations back. Joan's manuscript was rated significantly below John's, and it was the same manuscript. The only difference was John and Joan. It's amazing that several letters can make that much of a difference.

That paradigm has been used quite often in the child physical abuse literature to investigate how people respond to case data. And so, they'll have a vignette. Most of the research is done on ambiguous or mild indicators of abuse, which is our concern here. They will present these vignettes to a group of people with, say, a history of child physical abuse or no history of child physical abuse and in this case, there are physical abuse scenarios.

They find, for example, if you had a history of child physical abuse versus no abuse, as the worker who's looking at the case data, everything else being equal, you are significantly more often likely to confirm it as minor in each case. If you've been sexually abused, everything else being equal in the vignette, you see sexual abuse. If you believe children -- another variable -- tell the truth -- if you believe children tell the truth about things that happen to them, if you do a median split and put you into two groups, you're more likely to confirm child sexual abuse.

Personal characteristics -- I'll summarize all this literature -- the more similar you are to the person you're investigating, the less likely you are to confirm. If they're dissimilar from you, same case data, more likely. Okay. Greater age, this was a surprise for most of the researchers. That is to say, they thought younger people who were better informed would more likely confirm abuse in a vignette versus an older person looking at the same vignette. The opposite occurred. Older people were more likely to confirm than younger people.

Rater experience -- you're going to like this one. Workers typically say, "Let me sit with an abusive mom for 15 minutes and I'll tell you whether or not she's abusive. I can see it versus the non-abuser." Well, they compared professional social workers with experienced college students. The results were -- you know what's coming – the professionals were right 48% of the time, the students 52%. A coin toss in both cases. There's one later study where the professionals did a hair better, but experience doesn't guarantee very much is what it says.

Rater gender. There are at least ten studies in this area. Women confirmed more often than men in all sorts of cases. That is, physical abuse, mild and moderate; sexual abuse, mild and moderate. If you have a female worker, she's going to confirm more often.

Professional status. This interacts with the type of data. Again, I'm trying to summarize a lot of literature. Police, for example. If the person is highly emotional, if the child is really upset, or spouse abuse -- just a couple of those studies. If the woman is really upset, the police are likely to believe that assault occurred. If they're very calm, no. Now, mental health workers are the opposite. Emotionality doesn't influence them very much. I guess they see it all the time and they ask for objective data. I'm not going to go on. The point is non-case related data have an impact. It accounts for a significant amount of variance. If you put all these together in one situation, it may count for the majority of the variance. I don't know for sure that study hasn't been done.

When you talked last night about the rates changing across time, we went to definitions in the places we should go to. But if, for example, you're going out into the private sector and you're hiring more professionals to perform evaluations, are they different, are there more females? What's their racial makeup, et cetera? In other words, these characteristics, if they're not stable across these years when you're getting these rates, these characteristics will impact what is confirmed and not confirmed. So, you see where I'm going with the research study. Thank you.

DR. NEWBY: Well that, in some way, may relate in terms of the disproportionate number of African Americans. I mean, if you look at the military police who are called to a home, more often than not they're probably not African American military police who go. So, I mean, as you said that, then that sort of sparked that -- that perhaps that may have something to do with it also. When you said that the more alike you are to the person, then the less likely that you might believe that they have done something, react

more negatively. It seemed like that might be an area that could be studied also in terms of the military police who get called to homes in which there is some suspicion of violence.

DR. MILNER: That's a very simple study and very do-able which is what you need.

DR. URSANO: Next?

Maj LAWRENCE: Okay, I'm going to ask what I've just been talking about all day is that you just don't forget about the practitioners out there when you're looking at research. I would like to see a focus on looking at how to help practitioners improve screening for victims and families that are involved in family violence as the whole spectrum, not just separately child maltreatment, separately spousal abuse.

That needs to be done with some good educational research so you don't implement an ineffective program. That happens so frequently. I'm not so sure that some of these states that have requirements with our license. Gee, take four hours of CME every year at your willy-nilly, whatever you choose. Really, I don't believe that has any effect on me as a practitioner if I'm in one of those states.

So, I think you need to look at an effective educational tool. This could ultimately result in some policy in the Army or the military as to how practitioners receive training in this area. I guess I don't see it as being totally unrealistic that someday we have a mandatory requirement to routinely screen. I think it could be coming. JCAHO requires at least a policy to deal with domestic violence and that just came about in the '90s. Well, I guess I'm optimistic that maybe somewhere, you know, at the turn of the century, there will be a requirement for me as a practitioner to have to routinely screen for families involved in family violence. I guess that's where I'd like to see us ultimately heading.

DR. URSANO: Dan?

DR. O'LEARY: Yes. I might just add that I was at a conference -- seems like it was ten or more years ago -- that Koop organized in Williamsburg. I thought that he said that he was going to try to make one of the primary goals of the latter part of his administration to do exactly what you said. That all physicians were to be trained and it was to be a routine thing. Obviously, that part of his --

PARTICIPANT: He didn't get re-elected.

Maj LAWRENCE: He was a great leader -- it just never happened.

DR. O'LEARY: Yes.

COL MAYS: The fidelity didn't occur. It went out. I remember that effort. The American Bar Association has had their efforts also, but it just goes through one generation or cohort and --

Maj LAWRENCE: It needs to be general on family violence. It can't be child maltreatment here and spouse abuse here. I think it's a whole package and we have to stop separating it, at least as a screening point. I know treatment is different.

DR. O'LEARY: I'm sorry to divert. To take just a minute and thinking about the sort of cost and feasibility, I'd like to make three suggestions. One, the clinical risk equation which is a small cost issue. I think the field is at the point where they can do that and look at the relative risk of different things like I mentioned before.

Second, I think there's sort of – to use your expression, "Be All You Can Be" sort of adaptation, or whatever name you want to put on that for people where you can encourage as much self-referral as possible at the lower level would be a good idea. I failed to mention that the Ohio State Small Business Person's Association did a study about three years ago. They were interested in why people didn't perform so well, or why they were absent from their jobs. Since one of the issues here is about cost and feasibility and performance, they found that marital discord was higher than any other variable they had looked at, including alcohol (which was second) and drugs in terms of not performing well in the jobs or absenteeism. Some people might think, "Ah, that's a little too soft. You're only dealing with the minor stuff. You know, why spend money on it?" If one looks at performance and from a business standpoint, they thought it was quite important.

Finally, I like the idea, if it could be done -- even if it were moved into gradually, having a couple of centers of excellence at different bases where people would begin to look at one issue at a time, or several issues, because there really is nothing like that in the civilian sector and I think the Army could take a tremendous lead in that way.

DR. THOMAS: I'd like to make two points. One is while it's important to think of new research agendas, building a little bit on what you were saying this morning. I would urge people to take advantage of the wealth of data that has not been really exploited, the secondary analysis data that could be done to help build some good models to then take on to the research. I keep thinking the only people, the only people who have good co-occurrence data for the spouse and child abuse -- which is back to what you're saying -- where you can see it matched together is in the military. I mean, it's not quite as flashy and exciting as some of the other things we've been talking about, but it really is a pretty good resource.

There is another thing that I think is important, because I'm very interested in how you teach people. I'm from a land grant university which has an obligation to do extension work -- that is, to take the research out to people in a practical format. I'm really interested in what you're saying about not just giving knowledge out to people. I

did a paper about a year-and-a-half ago on how you train child protective workers to do sexual abuse forensic interviewing. I reviewed the literature and basically, you can't do it unless you tell them what you're going to teach them, teach them, make them practice it on, you know, actors and each other, videotape them, give them feedback, go out into the field, check them another six months later, and make sure that they have skill as well as knowledge. I think that whatever centers of excellence -- however you do that, that you have to put that whole package of knowledge, attitude change and skill together and that you've got to include that in your whole evaluation and research design or you're not going to get --

DR. FAFARA: I'm intrigued by the centers of excellence discussion, especially one aspect of it that focuses on the consumer acceptability and trying to determine whether the removal of the stigma or any negativity associated with provision of the services would increase, let's say, the positive outcomes. I also think that the risk appraisal model would be an easy sell for the military. It fits the mindset. I think it's a go.

DR. URSANO: Thanks, Richard. Hideji, any comments for us?

MAJOR KOMAI: I've learned quite a lot at this conference -- I think it is now time for me to report to Japan. If there's anything for me to say it is how to intervene in the discussion of family. For example, I think that a victim is apt to be co-dependent to the offender so they would not want to say the truth even to the psychotherapist or psychiatrist. To obtain the precise data, we'd have to develop some method to make them recover from their co-dependence.

DR. URSANO: I think we haven't used that word today. That's a good word to make sure we don't forget the co-dependence that occurs in these families around these issues. I would also, in speaking to you, Hideji, I'm reminded we have not really talked about cultural issues. We have sub-cultures within our own Department of Defense and certainly with the Army. We anticipate our population becoming even more culturally diverse. So, the issues of how these problems present and also can be treated in different cultures is of great importance to us. Kathy?

DR. WRIGHT: Yes. I think I would like to see research that focuses on more on the situational effects that may be particularly unique to the military. For example, the issue of deployments keeps coming up. There's no real definitive study that's been done, no well controlled study. If you could select units or installations that deploy with appropriate comparison and control groups, that might be something that could significantly contribute to pockets of distress, perhaps, in certain units. Related to that, field time or other chronic stresses that are specific to units.

DR. URSANO: Thanks, Kathy. Peter?

DR. JENSEN: Well, you know, it occurs to me that given the range of things people are interested in, one strategy might be to develop a research consortium that meets quarterly

that is a kind of a hard core of people that have interests in these areas. It seems like many people might draw on the research possibilities and you might develop, if you will, a menu of research studies. So, it might be over time, you'd develop the necessary infrastructure to put together a few centers, but there could also be secondary data analyses and policy studies, other evaluation studies.

I would certainly like to offer and hope that you'd work very closely with NIH and we'd like to work with you in terms of our research training programs you'd want to set up and get going because we're looking to create more infrastructure and create a larger research venue here. There's just, I think has been pointed out, research opportunities here that I don't think exist anywhere else. This has to be fostered and built over time.

What I would want to see happen is -- although it would be great, just, you know, like one study. I'd love to see a structure set up and some seeding of money that brings people together quarterly, who really are worker bees. A real work group I think could be of great value. We'd certainly love to support you in those efforts and work with you. We're close by so it would be easy to collaborate.

DR. URSANO: Thank you, Peter. Ann?

LTC NORWOOD: A lot of the things I would have commented on have already been said, especially the center of excellence and the ability to manipulate stressors, in particular deployment- related issues. I guess the other thing that was noted earlier is perhaps, again, an opportunity with the center of excellence in our different interventions as to put more focus on the pharmacological interventions maybe. You know, again, looking at that context.

DR. URSANO: Particularly treatment of depression?

LTC NORWOOD: I was thinking of depression and anxiety. Again, there are a lot of people, I know in our community in psychiatry that are interested in those research areas, and certainly people within University that are. People have had just great ideas. It was fun.

DR. URSANO: Delores?

MS. JOHNSON: I get another vote?

DR. URSANO: Sure.

MS. JOHNSON: I guess the only thing I haven't said, I really do want to endorse this notion of building this laboratory so that we can look at a number of things and build on having several people involved in that effort. While you were out of the room, we did a lot of picking about that and about your role in helping us get that done. We need to build Army talent to do research. We have good people, capable people, who could develop interests in this area, but we don't really have a mechanism to draw them in and

give them the talent and the time for that. So, whether that would be within a USUHS structure where we would develop fellows in family violence, but I very much want to see us grow our own talent.

DR. URSANO: Or a joint USUHS/NIH --

MS. JOHNSON: Within the Army.

DR. URSANO: -- many of those resources. Thank you. Bob?

COL MAYS: Yes. I guess I doodled here a little bit on the notion of our previous discussion where we talked about looking at a level of involvement in the family advocacy program, I guess on the lower end of the continuum where a family or couple may not become formally enrolled in our program while still getting some of the benefit of what we have to offer. I came up with four cells where we might be able to offer to the Chief of Staff of the Army, he would approve a demonstration project to look at the concept. Where we would perhaps randomly assign a couple, who after a thorough and proper assessment may be introduced to some brief treatment or sessions, with a letter to the commander -- no 2486. No formal enrollment in the program, and monthly monitoring by telephone up to a year.

The second cell would have sessions, no letter to the commander, no 2486 -- no enrollment -- with monthly monitoring for a year. The third cell the folks would have no sessions, no letter and monitoring for one year, no 2486. The fourth cell would receive nothing -- no interventions, no letter, no monitoring, and no 2486.

For whatever period of time this would take place we, perhaps, might be able to answer that commander's concerns about is there a way where the first time coupled, again, with whatever criteria we establish based on the expert knowledge of the field might be able to say, "This is what we can do with it."

DR. URSANO: This is really, Bob, as I understand, building on the alcohol model.

COL MAYS: More-or-less, the track one piece which proved to be, I think, successful. I don't know that we had any severe losses, any fatalities. Maybe some people within the track two which was still not the residential program. We still always have the capability with that monthly phone call to find out from the victim how things are going. The command in the community is so small. If it's out of hand we would not think -- unless they live in the civilian community. If we're going to find out, we're going to have to venture out there and see what's going on.

DR. URSANO: Thank you, Bob.

DR. BREWER: I think the centers of excellence idea is good. I think we need to also take a look -- I know in the drug and alcohol arena, they're doing that installation

prevention team training where they're going out to installations and identifying high risk units and then specifying certain kinds of interventions for those units. I'm just sort of curious as to where all that data stands and how it interfaces here. So, I think even within the Department of Army, some inter change alone, mental health drug and alcohol family -- is critical.

DR. URSANO: Ed?

DR. McCARROLL: There were a couple of comments that were made about the structure of the conference in terms of spouse and child abuse. John Newby and I talked about that when we were planning the conference. We first thought that maybe we ought to divide it between severe abuse and minor abuse, or sexual abuse and something, or men and women. So, finally, we decided we would stick with the standard categories of child and spouse, in spite of their limitations.

I know that at some Army installations, where they have large numbers of cases, they will have CRC committees that will meet one day and discuss child abuse and on another day they will discuss spouse about. I have heard that, many times, the participants in those meetings are different. So, what I'm getting at is this. I think there needs to be some thought around model building in terms of, What are the variables or what are the concepts?

I'd like to thank all of you who came and lent your expertise. I know Doctor Ursano will do that, but I want to add my own personal thanks for all your hard work and your suggestions. I also want to thank our USUHS group: John Newby, Kari McFarlan, Laurie Thayer, Chuck DiBello, and Ann Norwood. I also want to thank Doctor Ursano and Delores Johnson for their leadership and Carol Fullerton for helping us make slides. I'm very thankful to all of you and I'd like to give you all a big hand.

DR. URSANO: Thanks, Ed.

DR. GORDON: Just a comment about developing a research agenda in this area in the Army. I tend to think that a lot of it is kind of almost an attitudinal kind of issue. Myself, I was trained as a researcher first and I did clinical work. It's kind of like it requires like a act of intellectual courage, if you're a clinician, to really want to look at what you're doing and if it has any effect or not. I'm not even sure that we really want to find that out.

The value of that is that you step into kind of a more objective look at what's going on. If what you're doing is not effective, then you want to learn why it isn't. Usually, it's not all black and white. With some people it is effective and some it's not. It kind of helps you advance. I mean, it's the important role of research. It's a tool that can help develop clinical practice. It's one of the most valuable roles.

Research just doesn't do everything. It doesn't provide the services. It doesn't set the policy and so forth. It plays a role in that, but a very valuable role in it. I think as

we've heard particularly this afternoon in Jim and Dan's discussion that among researchers, is well recognized this distinction between the serious offenders and this high range. But among practitioners, the more astute clinicians will understand this – but, in the field itself, this has not really taken root.

This is really a significant issue which we know from knowledge and it should be acted on. I've heard a lot of kind of issues that you all have raised where the Army could use objective scientific information to learn something about what's going on. For example, like with the discussion about screening for domestic violence in primary care settings. There are some instruments in researcher want to know how well does that work? So, maybe one way is to give it and have intensive interviews with people to see how well it's working. That's the nature of the research process, trying to understand how well things are working and build objective knowledge to kind of guide policy and intervention.

I think that to a certain extent, what you need is to develop research agenda. I mean, it seems like the questions are anybody who works here could come up with a list of issues that would be important to know about to develop -- I think that what's needed is to institutionalize -- which actually is pretty rare. I mean, the academic and practice and research -- we have individuals. Like, for example, Dan and Joel have been working for years developing the lines of research and keep doing the next step and so forth. Those are pretty much individuals. We don't have too many institutions.

The private sector has some. Drug companies are typically trying to develop more, or car companies, but there aren't too many in the academic and research settings. We want to address questions in research, develop a line of research and keep it going, institutionalize it. I think you have an unusual opportunity in the Army. In NIH, where we have a researcher here, here, and here, and I think the field as a whole moves. But there's not like kind of a direction that you can set as an institution.

DR. URSANO: Appreciate that. Thank you.

DR. HAMPTON: Keeping in mind that the purpose of the armed forces is to fight and win wars, I would say the following. I'd like to see research that's designed to inform practice. Practice either in terms of how to keep a peace time force in full readiness, or should deployment or activation, mobilization become necessary how to field the most effective fighting force. I think if I were the commander, the bottom line is going to be performance in my primary duty.

Keeping that in mind, I think there are several subsets of things that I would like to see done or part of the research agenda. Recognizing that cultural diversity is a reality in the armed forces, I would certainly like to make sure that all the research we conduct is conducted in a way that takes into consideration both ethnic sensitivity and cultural diversity. I go back to Dan's earlier comment about breaking down different types of violence into long-term, short-term. I would also say maybe male/female, maybe there

would be other variables in there that might affect how we view this. I would certainly encourage the research agenda to look at existing data and to monitor it to the extent possible to help answer research questions that might inform practice and policy.

A small item that I was going to actually say earlier this morning is we may continually have to look at our gate keepers, whether it be the military police, whether it be other folks, who are the front line people who make decisions about who gets screened in, who gets screened out, and all the things that you mentioned in terms of some of the non-case variables which can actually affect how we process and respond to cases.

DR. URSANO: Thank you very much. Ray?

CDR EMANUEL: I was sitting here trying to think about how all this is going to translate into practical issues, putting on my clinician's hat. I think it's really going to start off with education. Clinicians, the people in the front lines, need to be included early on. These are the people that the data is going to have to flow through. That somebody is going to have to be in the front line. I remember Peter's inspirational grand rounds at Walter Reed which underscored the importance of clinicians becoming researchers. That is what has to be sold to the people working in the field. And I know how difficult that is to do with fellows and residents.

The other part is what I alluded to earlier which is how do we do the bridge building? What I heard here today is that some of the most problematic individuals and families have severe psychopathology, serious psychopathology. Why is psychiatry not included more in these evaluations? I do not routinely see kids who have been exposed to spouse abuse. If we're going to try and gather that data and try to implement programs targeted at either prevention or treatment of the individual, then it's going to take a lot more inter-departmental and inter-agency communication than is happening now.

So, some building of an infrastructure that has to occur before the research gets in place. But I think it's do-able because I think clinicians across the board will respond to understandable relevant research. If the model is there and they understand why the questions are being asked, and really take an interest in getting answers to them, then things will have a really organic quality and the research will grow, but I think if you try and impose the research on to the system as it stands, it's not going to work.

The other thing I thought about, you always have to remember the Cassandra effect, a high level of predictability does not mean anyone has to believe you.

But, I don't think that should discourage folks from doing research, but I do think that education, which consists of teaching that there are the serious consequences in terms of human suffering and money that may will be helped if you follow our recommendations. So, getting those the outcomes measures for preparedness and safety in concrete terms would be the thing that would sell the research to the command and make that link to the social and monetary concerns. But the bridge building, the

education, has to provide the infrastructure. Otherwise, we're well-intentioned folks sitting around talking about research but when it comes to actually getting this information from the field we will be frustrated.

DR. URSANO: Yes. John?

DR. NEWBY: There are a couple of things I'd like to see happen. One is that in terms of this whole notion about developing centers of excellence to be used as a laboratory for studying, you know, many of the things that we have talked about today. The other thing is that I really would be very interested in using the center of excellence as a laboratory for looking at differential methods of providing interventions, you know, based on the level of severity. I think that would be a very interesting piece of research for us to pursue.

As a former Army social worker and looking back, I remember and have some guilt about offering interventions just because that was what I had and it was not necessarily based on what the individuals needed. I think there are many of us -- there are a number of social workers or other health care professionals working in the field who do that, who give and offer what they have. That may not be based -- I mean, it's just that in terms of the lack of knowledge, lack of involvement with the research, or lack of knowledge about research. I think sometimes we think we're doing a good job. We may not be doing that in that we have not -- we're not basing our practice on something that's been tested and tried and shown to be in any way effective. So, that would be my interest.

DR. URSANO: Thank you, John.

LTC BRANNEN: One thing I guess, and being a clinician as well as a researcher, I tend to split my hats, I think, on clinician versus on the research. When I'm doing research, I tend to focus research. One of the things that struck me was a study I did with the Air Force family advocacy program two years ago looking at the knowledge base and what was available to the family advocacy folks in the Air Force. I found out that on average the total number of books read related to domestic violence that were all published within the last ten years -- that some of the seminal works that came out, Tolman & Edelson and Strauss' work, 0.8 was the average number of professional books read by the family advocacy officers and 1.5 journal articles read within the last year.

I thought that was really terrible so I asked the question, How many of you have this information available to you? I found out that professional books, recent publications or journals are not made routinely available to clinicians. I think the idea is to get it out to the clinicians not the researchers. We don't disseminate very well.

So, as a second step to that study, or a third step to that study, I went to my own library -- and I'm employed here on faculty at USUHS. We have no journals, or we had no journals relating to domestic violence and we had two books related to domestic

violence outside of my personal library two years ago. I think that's a sorry state of affairs for us.

I asked Delores, you can help us by disseminating the information or providing a mechanism that if we do do research blitz, get it out to the people that need it and let's get the current state of affairs out there. That's a challenge more-or-less.

DR. URSANO: Good. A moment of comment on that just because Delores has actually been very active in that area. I must say, particularly in terms of both getting information out on the newsletter and hopefully setting up a website which is an area of great interest. Jim?

DR. BREILING: Our progress in medicine and other areas has not been from clinical beliefs, but from science and technology. That's going to be true in our area. So, I really encourage you to put that as the premium of science and technology. There are limited resources everywhere. Limited resources for R&D, limited resources for services. I think in the R&D area, research and development, I really encourage you to think of a cumulative, systematic focused program of clinical development. Lots of things mentioned are diversions on the side and with limited resources, you really need to focus on the payoffs and approach that in a systematic way.

Part of that is to validate and automate and establish protocols for assessment and for treatment components so that you could do accurate and effective and efficient dispositions, based on needs and risk. A lot of that can be automated with the computer these days. Others can be specified in protocols. The waste in clinical time and dysfunction is just staggering. There's a ripe opportunity for development.

In the treatment area, I think we've got to cover multiple factors, but in the psychosocial area, we have to insist upon impact of dosage – for example, if someone is purporting to offer anger control, I wouldn't pay them a penny unless they have in vivo assessments of anger-provoking situations before treatment, during treatment, and after treatment. If they can't show changes in these in vivo things, marshmallow enema. I'm serious. We've really got to get down to business on this stuff.

Last, but not least on the anti-social personality disorder folks, I don't give up on them. They're very difficult. They're challenging. They have not received much attention. The severity and complexity of their problems is such that they need the intensity and potency of the intensive care unit. What we've done is fiddle around the edges and kind of blame them, and fault them, and zap them and guillotine them, but not bring the intensity and potency of focus of serving the need there.

I think, in many cases, knowing a number of these people, there are bright, potential lights out there that are worth saving for their benefit and for the protection of others. The punitive approach is not the right one, but we have not matched that with organized systematic efforts on their behalf.

DR. URSANO: Thank you all for a marvelous conference. I was absolutely accurate on speaking of bright people who were verbal and would get into a sufficient amount of discussion and debate to make for an exciting and pleasant day.

I think we're about on time to wind up and thank you all.

NONCASE RELATED FACTORS ASSOCIATED WITH CHILD ABUSE EVALUATIONS/REPORTING

CHILDHOOD ABUSE HISTORY

BELIEFS

PERSONAL CHARACTERISTICS

RATER AGE

RATER EXPERIENCE

RATER GENDER

PROFESSION

LEGAL ROLE

Figure 1